

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8105

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08086

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Coroner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

X

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 5 hrs.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Pr. Geo's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING BROOK HIGH SCHOOL		d. STREET ADDRESS R.F.D. #1, Box 210 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARNE First Middle Last		4. DATE OF DEATH JULY 25 Month Day Year	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/95
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employd Carpenter	
11. BIRTHPLACE (State or foreign country) NORWAY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown AARO Thomas		14. MOTHER'S MAIDEN NAME RAGNILD UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) --		16. SOCIAL SECURITY NO. 052-07-1654	
17. INFORMANT Mrs. Dorothy E. Aaro, R.F.D.#1, Box 210 Address Brandywine, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO (b) Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John G. Ball EXAMINER'S NAME (Type) JOHN G. BALL		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 25 July 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/27/60	22c. NAME OF CEMETERY OR CREMATORY Immanuel Cemetery	22d. LOCATION (City, town, or county) (State) Horsehead Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home ADDRESS Upper Marlboro, Md.		24a. REC'D BY REGISTRAR JUL 29 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

FOR STATE
HEALTH DEPT.

1915

MISSISSIPPI STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER - CIVIL DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, date, and place of death. The form is mostly blank with some faint handwriting visible on the left side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8106

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08087

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2008 Glen Ross Road</u>				d. STREET ADDRESS <u>2008 Glen Ross Road</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Martin</u> Last <u>Abel</u>				4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1960</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 16, 1920</u>			
9. AGE (In years lost birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>9</u> Hours <u>14</u> Min. <u>39</u>		IF UNDER 24 HRS. Hours <u>14</u> Min. <u>39</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Budget Analyst</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Govt - US Dept. of Agriculture</u>					
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank J. Abel</u>				14. MOTHER'S MAIDEN NAME <u>Cora Deitrich</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW 2</u>				16. SOCIAL SECURITY NO. <u>Yes</u>					
17. INFORMANT <u>Mrs. Jeanne T. Abel, 2008 Glen Ross Rd., S.S., Md.</u>				Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sarcoma of Spleen ± Metastases</u> DUE TO (b) <u>199.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>199.1</u> DUE TO (c) <u>199.1</u>								INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1959</u> to <u>July 1960</u> that (I) (we) last saw the deceased alive on <u>7/13</u> 19 <u>60</u> and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Maurice Franks</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>7/14/60</u>					
22c. PHYSICIAN'S NAME (Type) <u>Maurice Franks</u>				22d. ADDRESS <u>901 20th NW, Wash D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 18, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Humphrey, Inc., Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>DATE JUL 19 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8187

MONTGOMERY STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08088

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 7 Thompson			
3. NAME OF DECEASED (Type or print) First Robert Middle John Last AKIN				4. DATE OF DEATH Month July Day 3 Year 1960			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH May 23 1925	9. AGE (In years last birthday) 35 yrs.	IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	IF UNDER 24 HRS. Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Joseph AKIN				14. MOTHER'S MAIDEN NAME Cathrine Malanify			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 3-20-43 081 32 6424		17. INFORMANT Address Mrs. Cathrine AKIN (2 above)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 201X IMMEDIATE CAUSE (a) Hodgkins Disease DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Troy	(County) New York		(State)	
21. I certify that (I) (this hospital) attended the deceased from June 24 19 60 to July 2 19 60 , that (I) (we) last saw the deceased alive on 2 July 19 60 , and that death occurred at 0903 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John Wood Davis				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN WOOD DAVIS LT MC USN				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-6-60		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Troy New York	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest A. Adams ADDRESS Adams Funeral Home, 2748 Wisconsin Ave., NW, WDC				25a. REC'D BY REGISTRAR DATE JUL 6 '60		25b. REGISTRAR'S SIGNATURE Charles E. Kneass	

[Faint, illegible text covering the main body of the page, likely bleed-through from the reverse side.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8188

CERTIFICATE OF DEATH

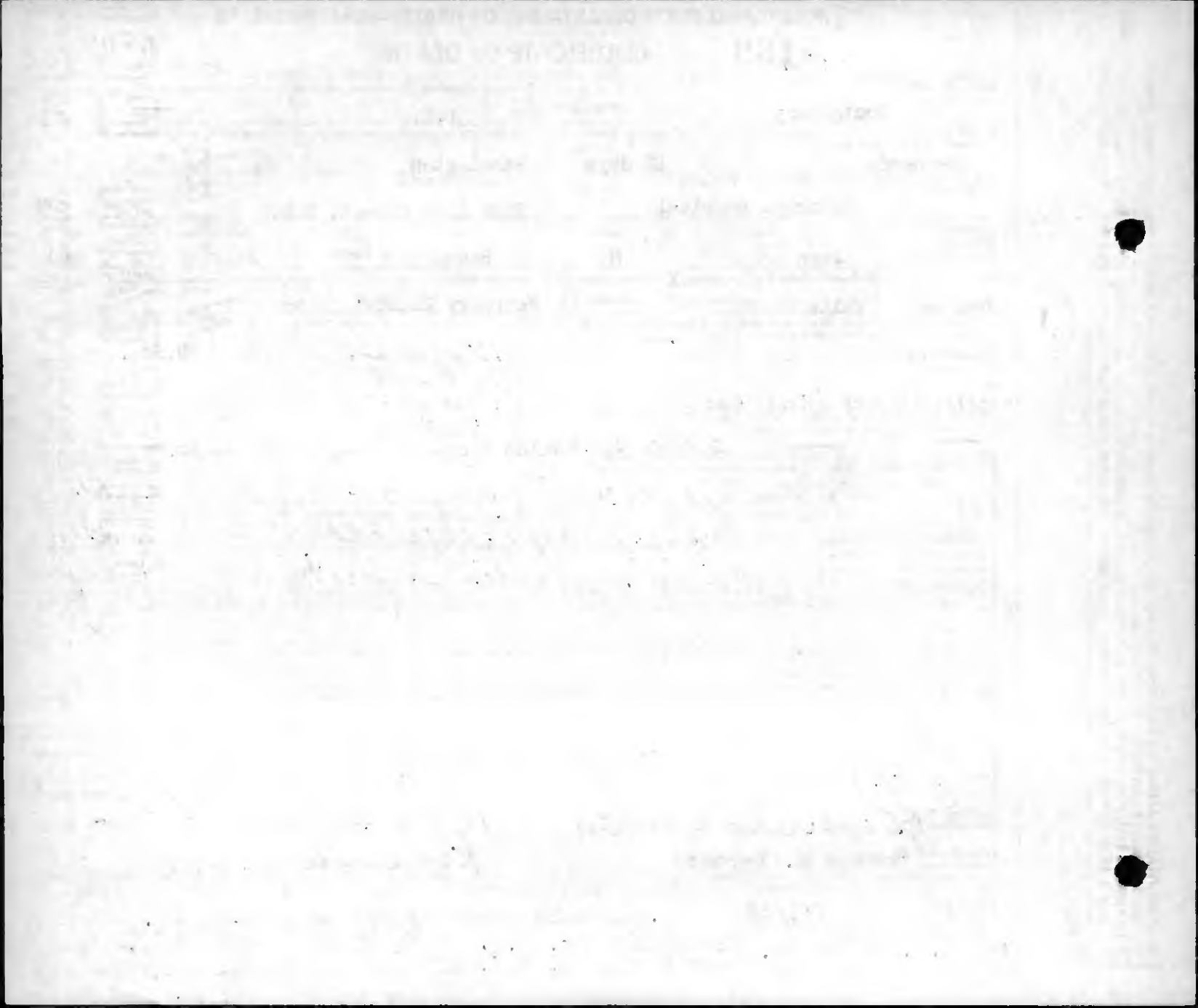
Reg. Dist. No.

08089

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 5 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		d. STREET ADDRESS 4550 Conn. Ave. NW.	
3. NAME OF DECEASED (Type or print) First Olivia Middle D.C. Last Andersen		4. DATE OF DEATH Month July Day 9 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/84
9. AGE (In years lost birthday) 75 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper	
11. BIRTHPLACE (State or foreign country) Denmark		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT 500 W. Montg. Ave. Dr. Dexter Bullard- Rockville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Infarction, left 420.1 DUE TO Embolicism, left middle cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. DUE TO Myocardial Infarction with mural thrombus, left apex (c) 8 Days			INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb , 19 60 , to July 9 , 19 60 , that I last saw the deceased alive on July 8 , 19 60 , and that death occurred at 7:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Corinne Cooper		ADDRESS (Street, city or town, state) 104 S Washington St. Rockville Maryland.	
PHYSICIAN'S NAME (Type) CORINNE COOPER		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/11/60	22c. NAME OF CEMETERY OR CREMATORY Rockville	22d. LOCATION (City, town, or county) (State) Rockville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler, Rockville, Md		24a. REC'D BY REGISTRAR DATE JUL 12 '60	24b. REGISTRAR'S SIGNATURE Clifford S. Hanna

MEDICAL CERTIFICATION

11/23/2011 11:54 AM 2011 11/23/2011 11:54 AM





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08091

8190

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE New York b. COUNTY Penfield		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Penfield		
c. LENGTH OF STAY IN 1b 7 days			d. STREET ADDRESS 1925 Baird Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Jack Joseph Barbieri			4. DATE OF DEATH Month July Day 29 Year 19 60		
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 16, 1925		9. AGE (In years lost birthday) 35 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY (Unknown)	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Louis Barbieri			14. MOTHER'S MAIDEN NAME Sabina Parchi		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II Unascertainable	17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cryptococcal Meningitis DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hodgkin's Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 22 19 60 to July 29 19 60 that (I) (we) last saw the deceased alive on July 29 19 60 , and that death occurred 7:45pm , from the causes and on the date stated above					
22a. SIGNATURE 		22b. DATE SIGNED 7-30-60		22c. PHYSICIAN'S NAME (Type) W. ANDERSON SPICKARD, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-30-60		23b. DATE THEREOF 7-30-60		23c. NAME OF CEMETERY OR CREMATORY St. Charles Pinelawn	
23d. LOCATION (City, town, or county) Long Island, New York					
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR DATE AUG 3 '60	
25b. REGISTRAR'S SIGNATURE 					

Burial-transit 7-30-60

St. Charles Pinelawn

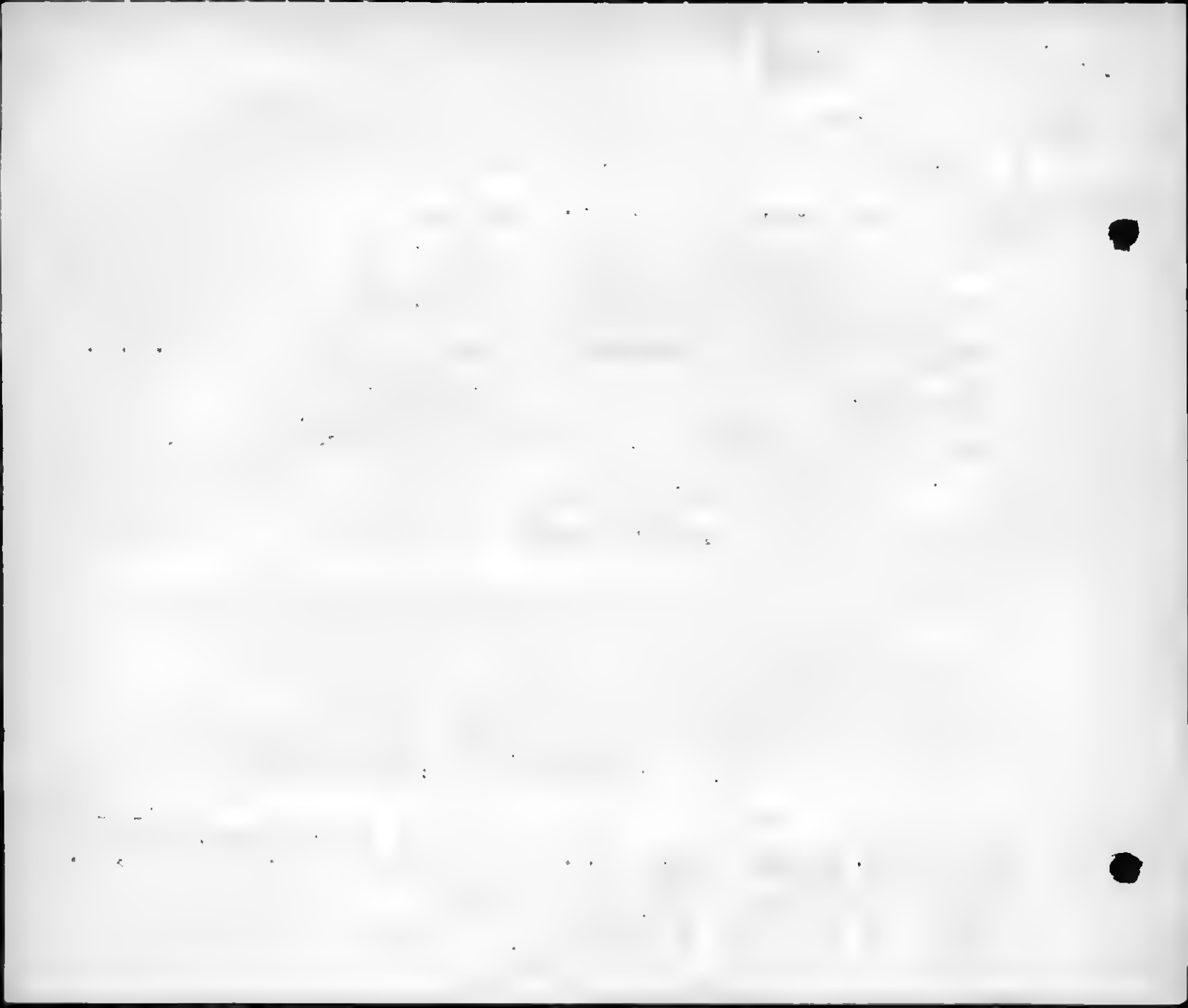
Long Island, New York

ROBERT A. PUMPHREY

Bethesda, Md.

AUG 3 '60

Arthur S. Kraus



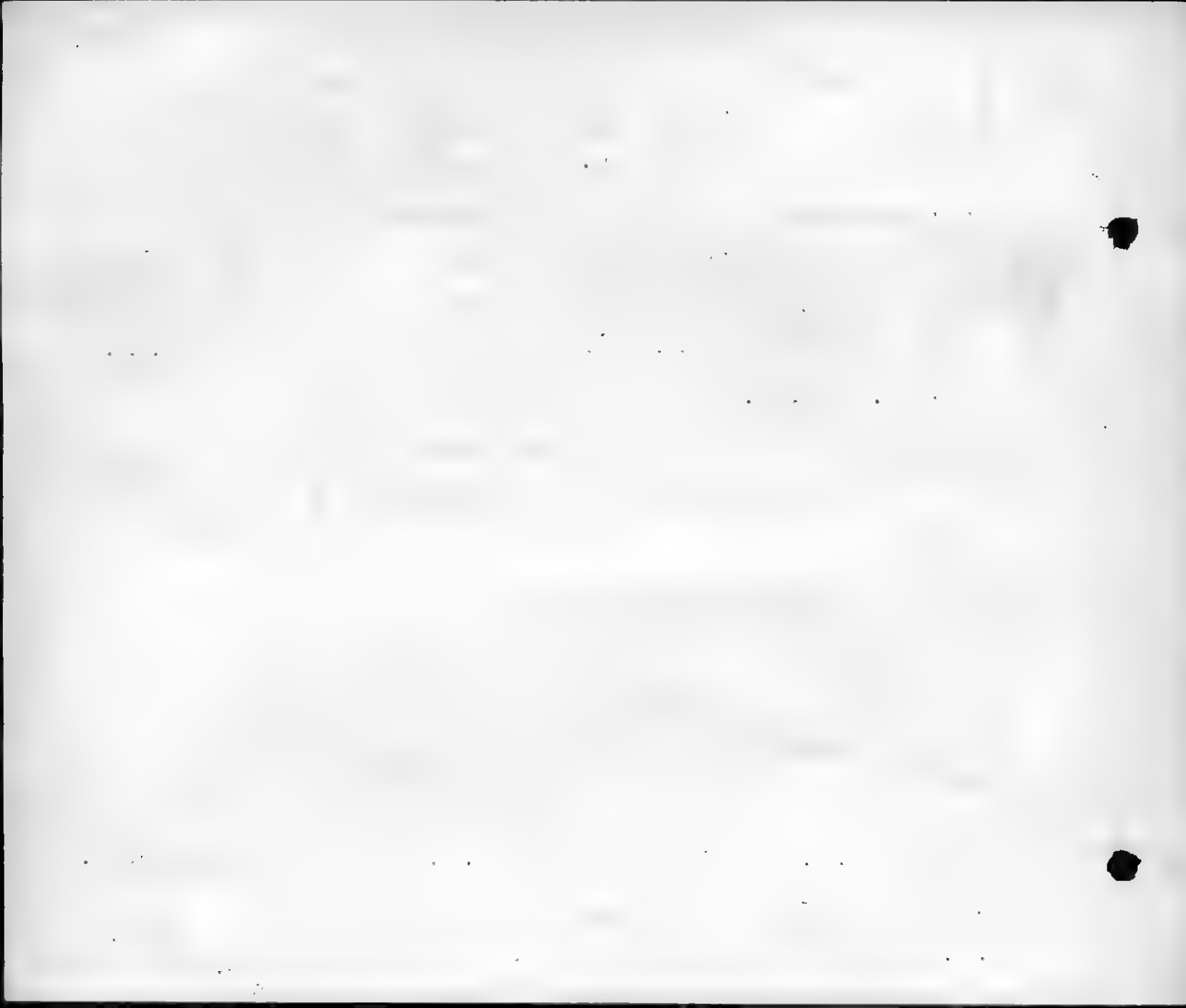
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08092

8191

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 1/2 hrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Bryans Road Trailer Camp			
3. NAME OF DECEASED (Type or print) First Baby Girl Middle BARNA Last July				4. DATE OF DEATH Month 12 Day 1960			
5 SEX Female		6 COLOR OR RACE Caucasian		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 7-12-60	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS		9. AGE (In years last birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph G. BARNA, Sr.				14. MOTHER'S MAIDEN NAME Jacqueline OSTRANDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 7761 IMMEDIATE CAUSE (a) Immaturity (26 weeks gestation) DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO DUE TO							INTERVAL BETWEEN ONSET AND DEATH 2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (the doctor) attended the deceased from Birth to July 12, 1960 , that (I) (we) last saw the deceased alive on July 12, 1960 , and that death occurred at 9:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE John H. Mazur				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-13-60	
22c. PHYSICIAN'S NAME (Type) J. H. MAZUR, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMAT. OR REMOVA. (Specify) Burial		23b. DATE THEREOF 7-15-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey				25a. REC'D BY REGISTRAR DATE JUL 15 '60		25b. REGISTRAR'S SIGNATURE R. A. Pumphrey	



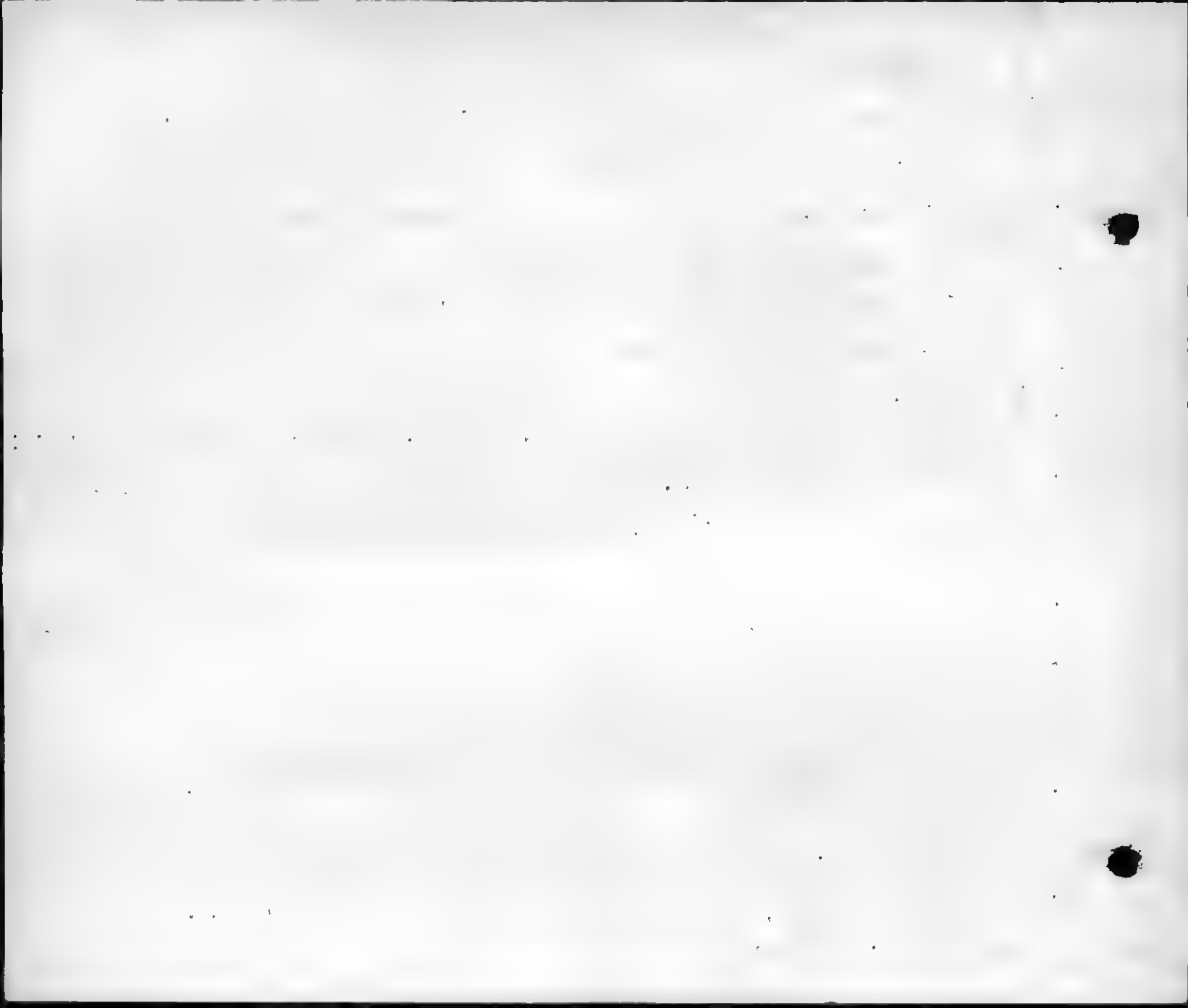
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Dr. Frank J. Broschart, Dep. Med. Exam. notified and approved.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND					
8107					
CERTIFICATE OF DEATH					
08093					
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 13 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8113 Carroll Lane			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 8113 Carroll Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Edna R. Bassett			4. DATE OF DEATH July 8 1960		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 30, 1880		9. AGE (In years last birthday) 80 yrs		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) District of Columbia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John L. Bentzler			
14. MOTHER'S MAIDEN NAME Anna Clements		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Forest M. Bentzler, 8113 Carroll Lane, S.S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) Coronary occlusion DUE TO (b) Coronary insufficiency DUE TO (c) Diabetes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes INTERVAL BETWEEN ONSET AND DEATH 5 yrs					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Washington, D.C.		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 20, 1956 to July 8, 1960 that (I) (we) last saw the deceased alive on June 18, 1960 and that death occurred at 11:30 M., from the causes and on the date stated above.					
22a. SIGNATURE R. Lee Spire		22b. DATE SIGNED July 8, 1960		22c. PHYSICIAN'S NAME (Type) R. Lee Spire	
22d. ADDRESS 4600 Connecticut Ave Wash DC		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 11, 1960		23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEMETERY	
23d. LOCATION (City, town, or county) WASHINGTON, D.C.		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC., SILVER SPRING, MD.		25a. REC'D BY REGISTRAR Jul 13 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08094

8192

CERTIFICATE OF DEATH

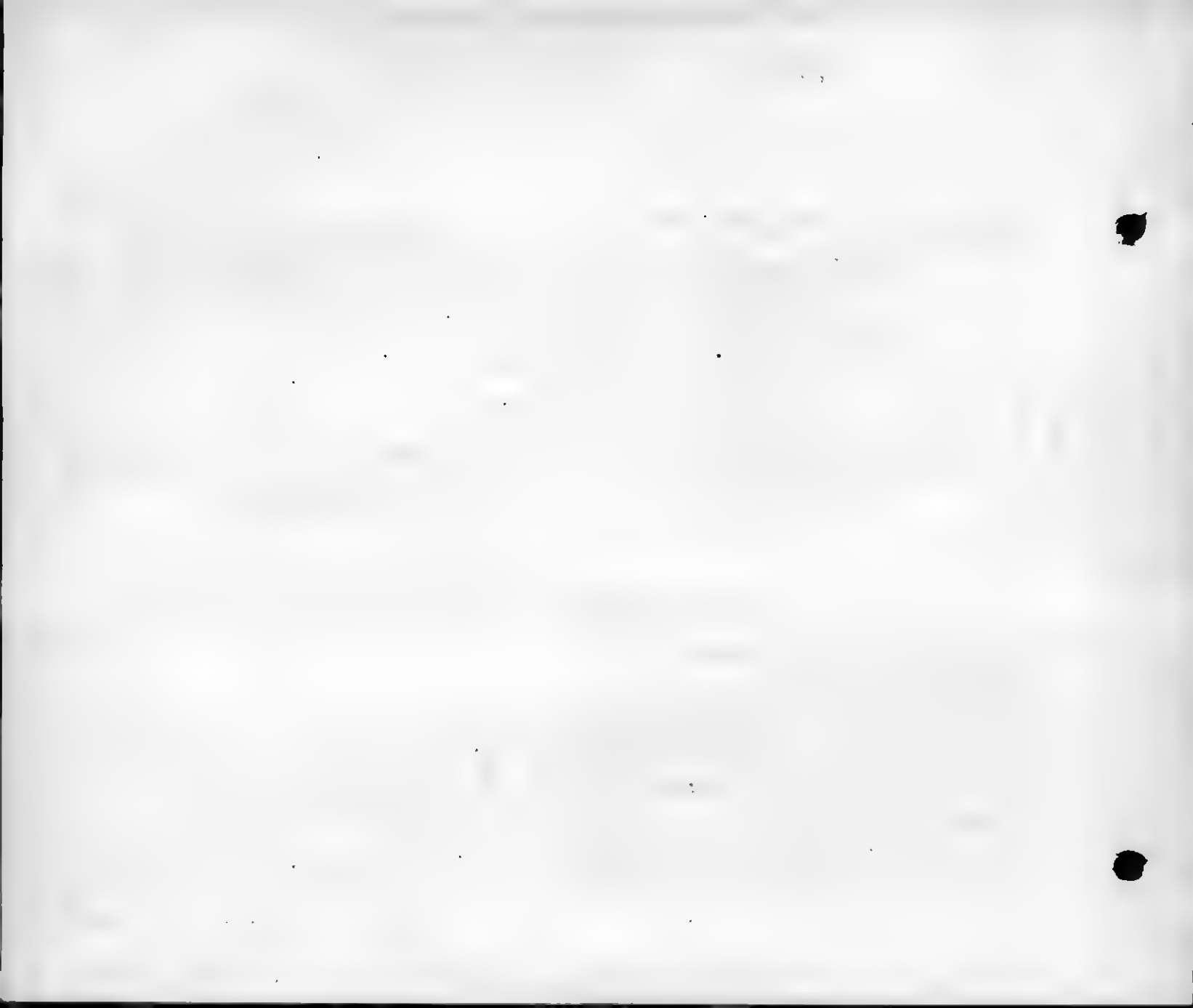
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>NEW ROUTE 29</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>NEW ROUTE 29</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>L.</u> Last <u>BEALL</u>		4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 29, 1898</u>
9. AGE (In years last birthday) <u>61</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL CROP FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>BURTONSVILLE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WM. EDWARD BEALL</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN MERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-38-3834</u>	
17. INFORMANT <u>MRS. HELEN GIBSON BEALL, BURTONSVILLE, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CIRCUMSCRIBED, PERITONITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/19/60</u> to <u>7/21/60</u> , that I last saw the deceased alive on <u>7/19/60</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>F. K. Weaver</u>			
PHYSICIAN'S NAME (Type) <u>320 Montgomery</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>July 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BURTONSVILLE, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanes</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>

MEDICAL CERTIFICATION

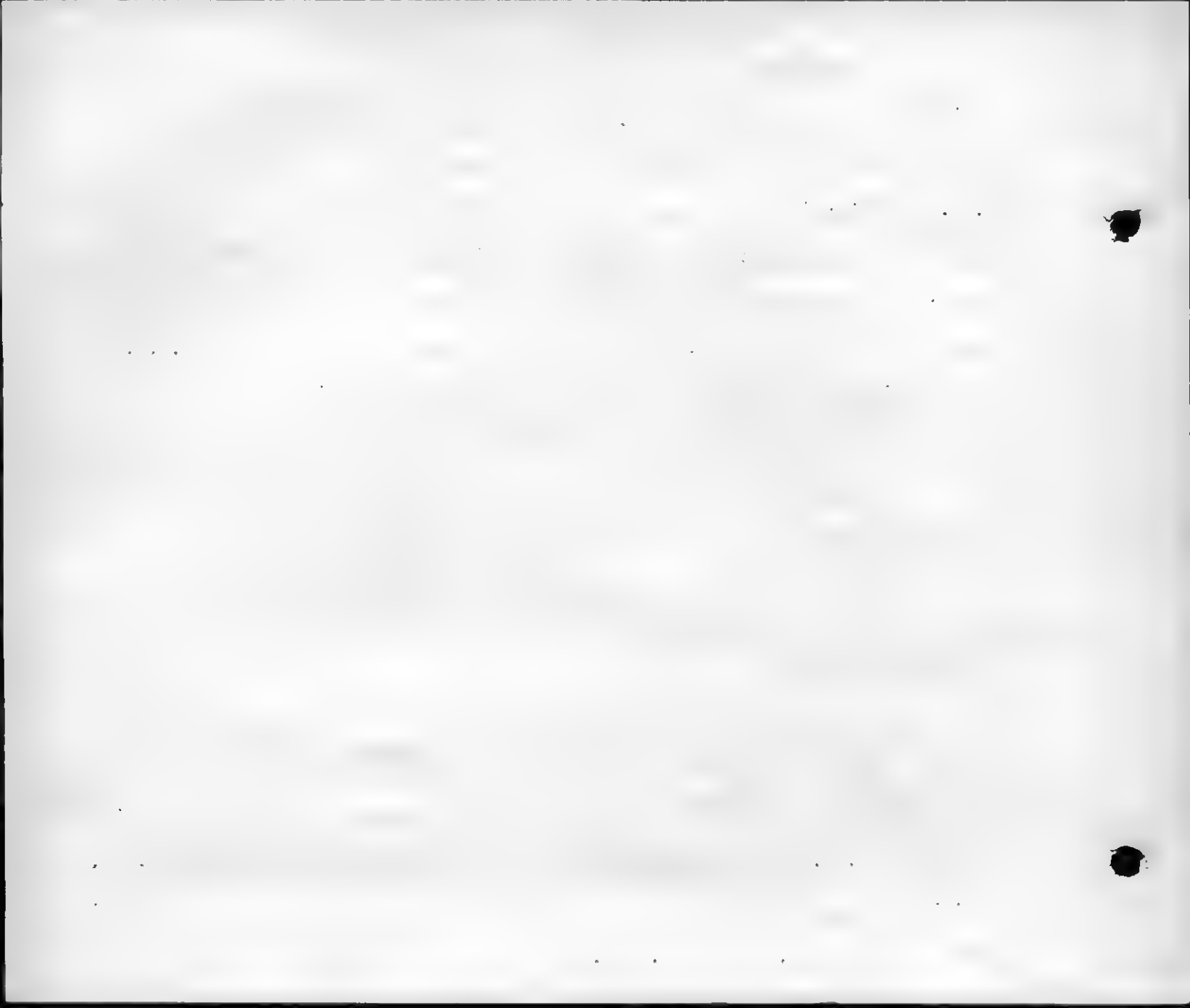
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8192

✓✓✓✓✓✓✓✓✓✓



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8194

CERTIFICATE OF DEATH

Reg. Dist. No.

08096

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>16 Princeton Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Elizabeth</u> Last <u>Boose</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>1960</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 27, 1890</u>	9. AGE (In years last birthday) yrs. <u>69</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>John Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Alice King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-03-4658</u>		INFORMANT Address <u>Catherine Smith 16 Princeton Ave. Glen Echo, Md.</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> DUE TO (b) <u>arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 1, 1960</u> to <u>July 9, 1960</u> that I last saw the deceased alive on <u>July 8, 1960</u> and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>615 W. Montgomery Ave. Rockville, Md.</u> DATE SIGNED <u>7/9/60</u>					
ACTUAL SIGNATURE <u>Stephen C. Cronwell, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Stephen C. Cronwell, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Prince George Co. Md.</u>		22e. (State) <u> </u>		22f. (Country) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Robert A. Rumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jul 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

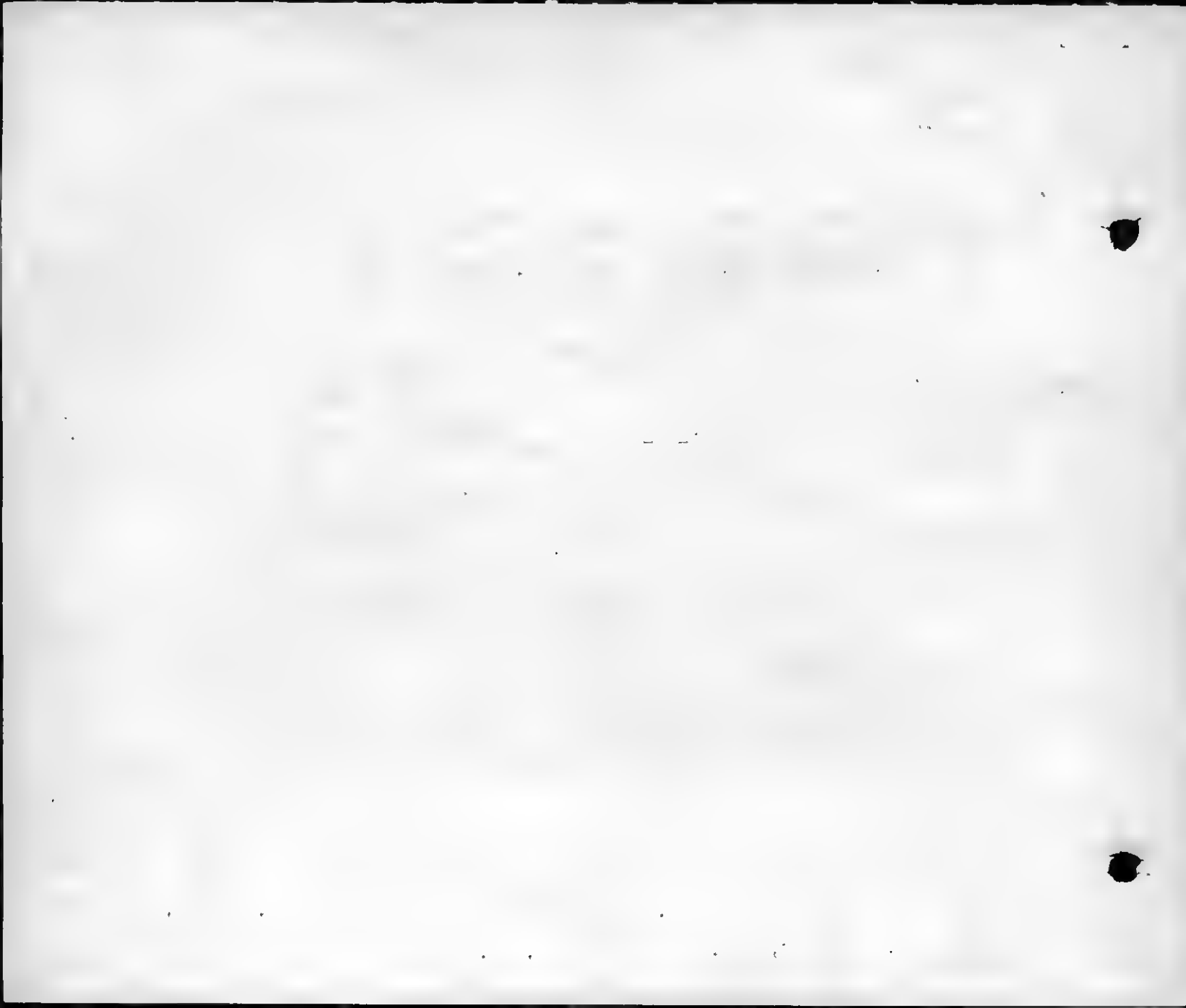
VR A15 (4)
 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8133

08098

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DC</u> b. COUNTY			
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. SAN. Hosp.</u>				d. STREET ADDRESS <u>6121 8th St NW</u>			
3. NAME OF DECEASED (Type or print) <u>MICHELE A. BOZZI</u>				4. DATE OF DEATH Month <u>7</u> - Day <u>30</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Italian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1881</u>	9. AGE (In years last birthday) <u>79</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>RUCIO BOZZI</u>			
14. MOTHER'S MAIDEN NAME <u>ROSALIA COSTA</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			
16. SOCIAL SECURITY NO. <u>579-03-6873</u>				17. INFORMANT <u>James J. Bozzi 321 Hillmore Dr. S.S.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>12 hrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/28/1960</u> to <u>7/30/1960</u> , that (I) (we) last saw the deceased alive on <u>7/30/1960</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Donald Nelson</u> M.D.				22b. DATE SIGNED <u>7/30/60</u>		22c. PHYSICIAN'S NAME (Type) <u>DONALD NELSON</u>	
22d. ADDRESS <u>10620 Georgia Ave, Silver Spring, Md.</u>				23a. REC'D BY REGISTRAR <u>AUG 3 '60</u>			
23b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>				23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>			
23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>				23e. DATE THEREOF <u>8/2/60</u>			
23f. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23g. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>			
23h. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>				23i. DATE THEREOF <u>8/2/60</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>				ADDRESS <u>SILVER SPRING, MD.</u>		25a. REC'D BY REGISTRAR <u>AUG 3 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>				25c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>			
25d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>				25e. DATE THEREOF <u>8/2/60</u>			

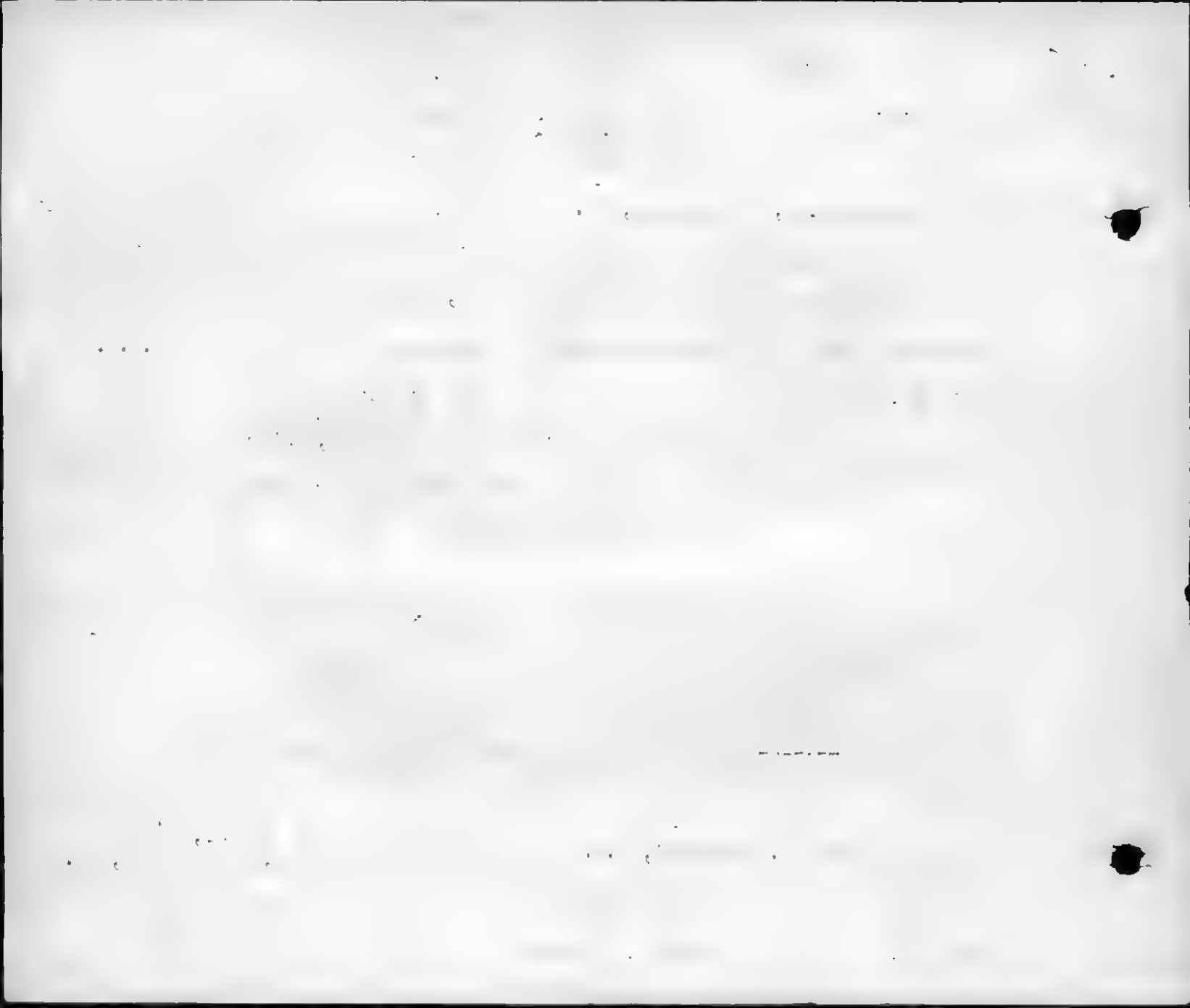


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8195
CERTIFICATE OF DEATH
08095

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 119 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Washington b. COUNTY Ocean Park c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 121 d. STREET ADDRESS Box 121 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Gordon Leroy Brice			4. DATE OF DEATH Month Day Year July 27 1960				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 28, 1913		9. AGE (In years last birthday) yrs. 47		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager and Owner		10b. KIND OF BUSINESS OR INDUSTRY Motel Management		11. BIRTHPLACE (State or foreign country) Washington			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Charles Brice			14. MOTHER'S MAIDEN NAME Ada Keller				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unascertainable		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastrointestinal hemorrhage → shock DUE TO (b) Homologous serum hepatitis DUE TO (c) _____ Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH 8 hours 1 week		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Clark County Washington			
21. I certify that (I) (the hospital) attended the deceased from March 30, 1960 to July 27, 1960 , that (I) (we) last saw the deceased alive on July 27, 1960 , and that death occurred at 8:25 AM from the causes and on the date stated above.							
22a. SIGNATURE Edward J. Laskowski		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 7/27/60		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Edward J. Laskowski, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 7/28/1960		23c. NAME OF CEMETERY OR CREMATORY Ridgefield			
23d. LOCATION (City, town, or county) Clark County Washington		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUL 29 '60		
			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8179

CERTIFICATE OF DEATH

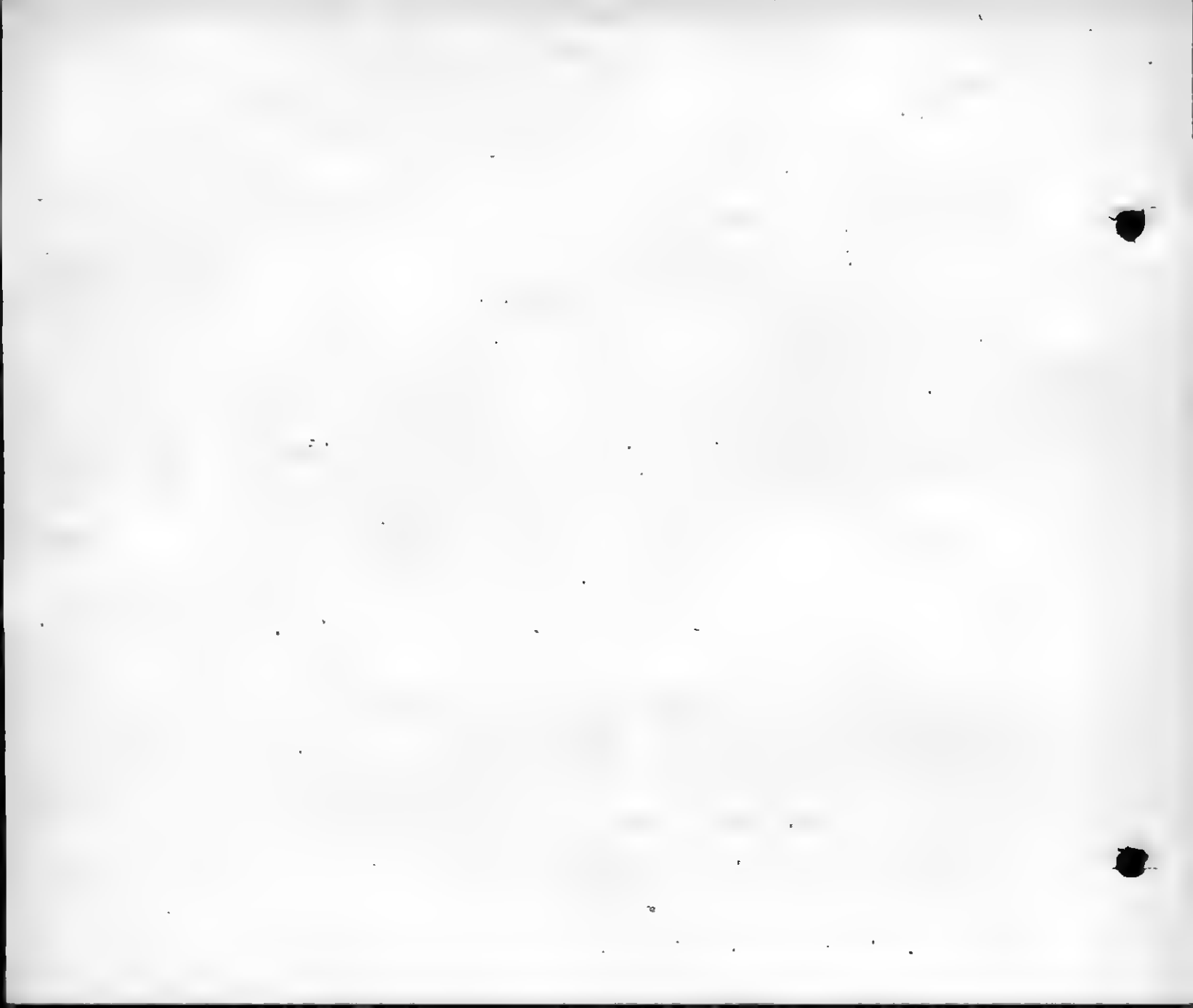
08100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b X		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X		d. STREET ADDRESS 13775 Travilah Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LILLY MAY BRIDGE		First		Middle		Last		4. DATE OF DEATH July 16,		Month		Day		Year 19 60	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/17/1893		9. AGE (In years last birthday) 67 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME Walter Grimes								14. MOTHER'S MAIDEN NAME Annie Grimes							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				INFORMANT Henry W. Bridge-Item#2				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 44-3X IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO 8 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Ht. Failure DUE TO (c) Hypertension & A-S-C-V-D. 10 yrs												INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of breast & metastases															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)				(County)				(State)			
21. I certify that I attended the deceased from Nov. 1, 19 50 , to 7/16/ 19 60 , that I last saw the deceased alive on 7/16/ 19 60 , and that death occurred at 5:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rockville, Md. DATE SIGNED 7/17/60															
ACTUAL SIGNATURE Stephen N. Jones				M.D. Rockville, Md.				PHYSICIAN'S NAME (Type) Stephen N. Jones				Rockville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/19/60				22c. NAME OF CEMETERY OR CREMATORY Parklawn				22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler-1331 E. Mtg. Ave. Rockville, Maryland								24a. REC'D BY REGISTRAR DATE JUL 19 '60				24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

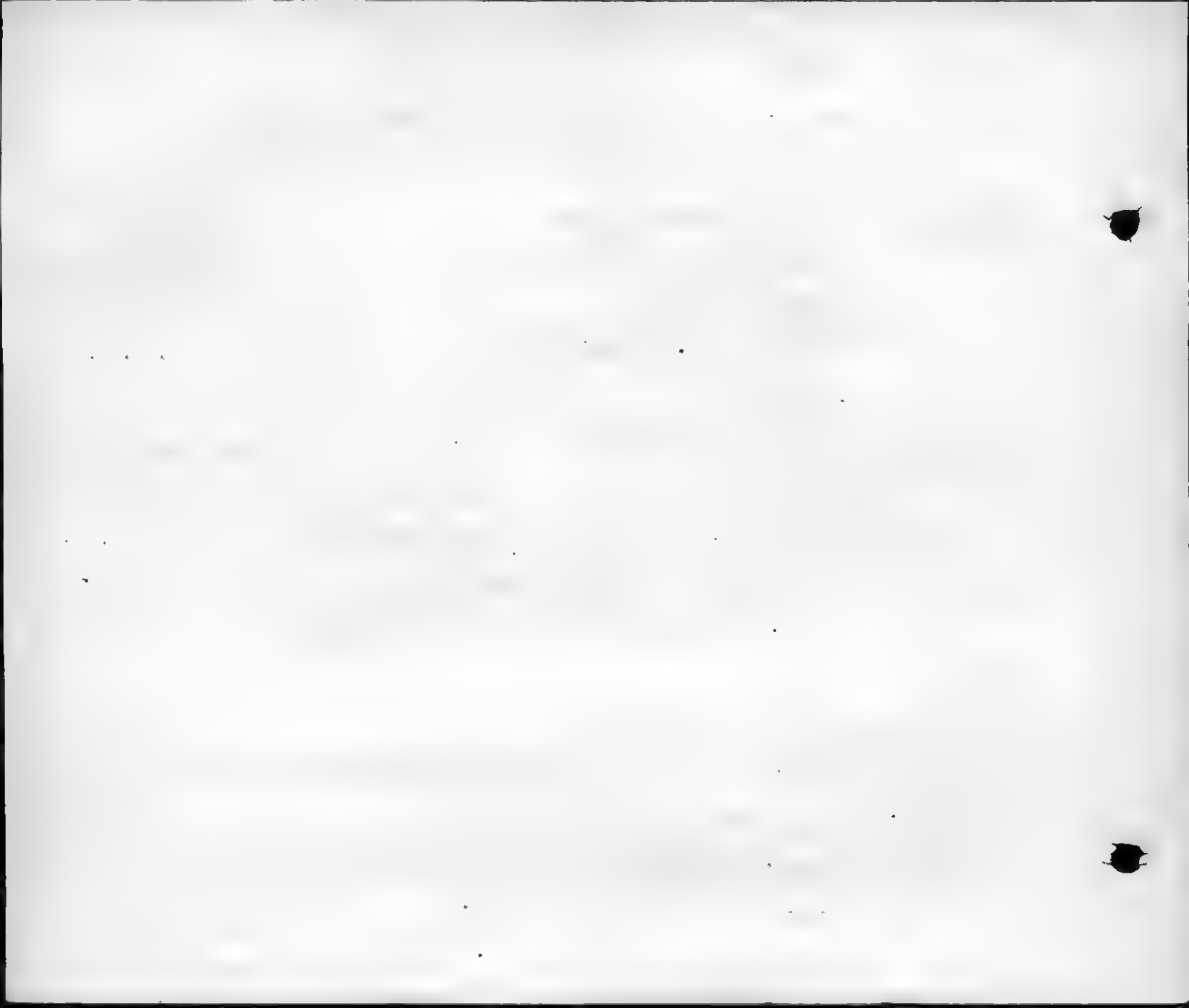
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8196

08101

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON GROVE			
c. LENGTH OF STAY IN 1b 2 DAYS				d. STREET ADDRESS 313 BROWN STREET			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle LUCIAN Last BRIGHAM			4. DATE OF DEATH Month JULY Day 12 Year 1960				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/90		9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY Gen. Construction			11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN T. BRIGHAM				14. MOTHER'S MAIDEN NAME ANNIE CROWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 578 05 5820		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIAL HYPERTENSION DUE TO (c) CORONARY ARTERY DISEASE							INTERVAL BETWEEN ONSET AND DEATH 5 DAYS 20 YEARS 15 YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS - GASTRIC ULCER							19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from MAY 12 1960 to JULY 12 1960 , that (I) (we) last saw the deceased alive on JULY 12 1960 , and that death occurred at 12:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE Gordon S. Rosenberger				22b. DATE SIGNED July 13, 1960		22c. PHYSICIAN'S NAME (Type) GORDON S. ROSENBERGER, M. D.	
22d. ADDRESS ROCKVILLE, MARYLAND							
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-15-60		23c. NAME OF CEMETERY OR CREMATORY Darnestown Pres.		23d. LOCATION (City, town, or county) (State) Darnestown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE JUL 19 60	
				25b. REGISTRAR'S SIGNATURE Charles S. Kline			

MEDICAL CERTIFICATION

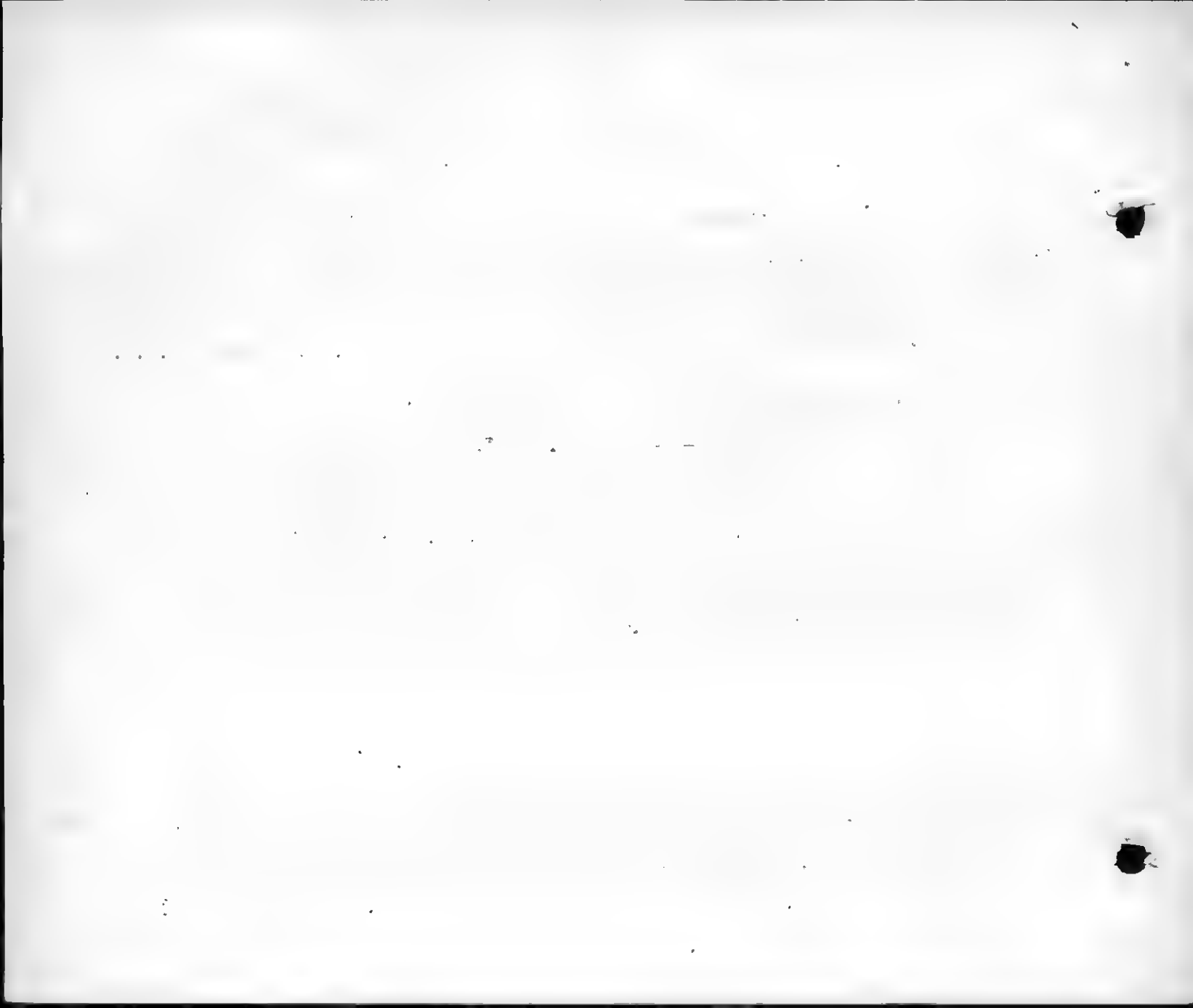


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Item 7 Film G267 7/14/60 iwk											
Heart disease 8197											
CERTIFICATE OF DEATH											
Reg. Dist. No. 08102											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 2 1/2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital						d. STREET ADDRESS 4113 Knowles Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Wilfred Last Broadhurst						4. DATE OF DEATH Month 7 Day 6 Year 1960					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/14/020		9. AGE (In years last birthday) 57 yrs		10. IF UNDER 1 YEAR Months 10 Days 22 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Warthen & Ward		11. BIRTHPLACE (State or foreign country) Montgomery Co. Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Broadhurst						14. MOTHER'S MAIDEN NAME Artie C. Hagar					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216-16-0425		INFORMANT Ella E. Broadhurst				Address Wife same as above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]											
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Infarction, pons, right										INTERVAL BETWEEN ONSET AND DEATH 6 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Thrombosis, Posterior communicating artery										6 days	
(c) 											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Bronchopneumonia											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1950 to date , 19 60 , that I last saw the deceased alive on 6 July 19 60 , and that death occurred at 5:05 P. M. from the causes and on the date stated above.											
ACTUAL SIGNATURE John G. Ball						ADDRESS (Street, city or town, state) 7936 Old Georgetown Rd.				DATE SIGNED 7/7/60	
PHYSICIAN'S NAME (Type) John G. Ball, M. D.						Bethesda, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/9/60		22c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery				22d. LOCATION (City, town, or county) (State) Rockville, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey						ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



TO HOSPITAL OR ATTENDING PHYSICIAN: The form requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

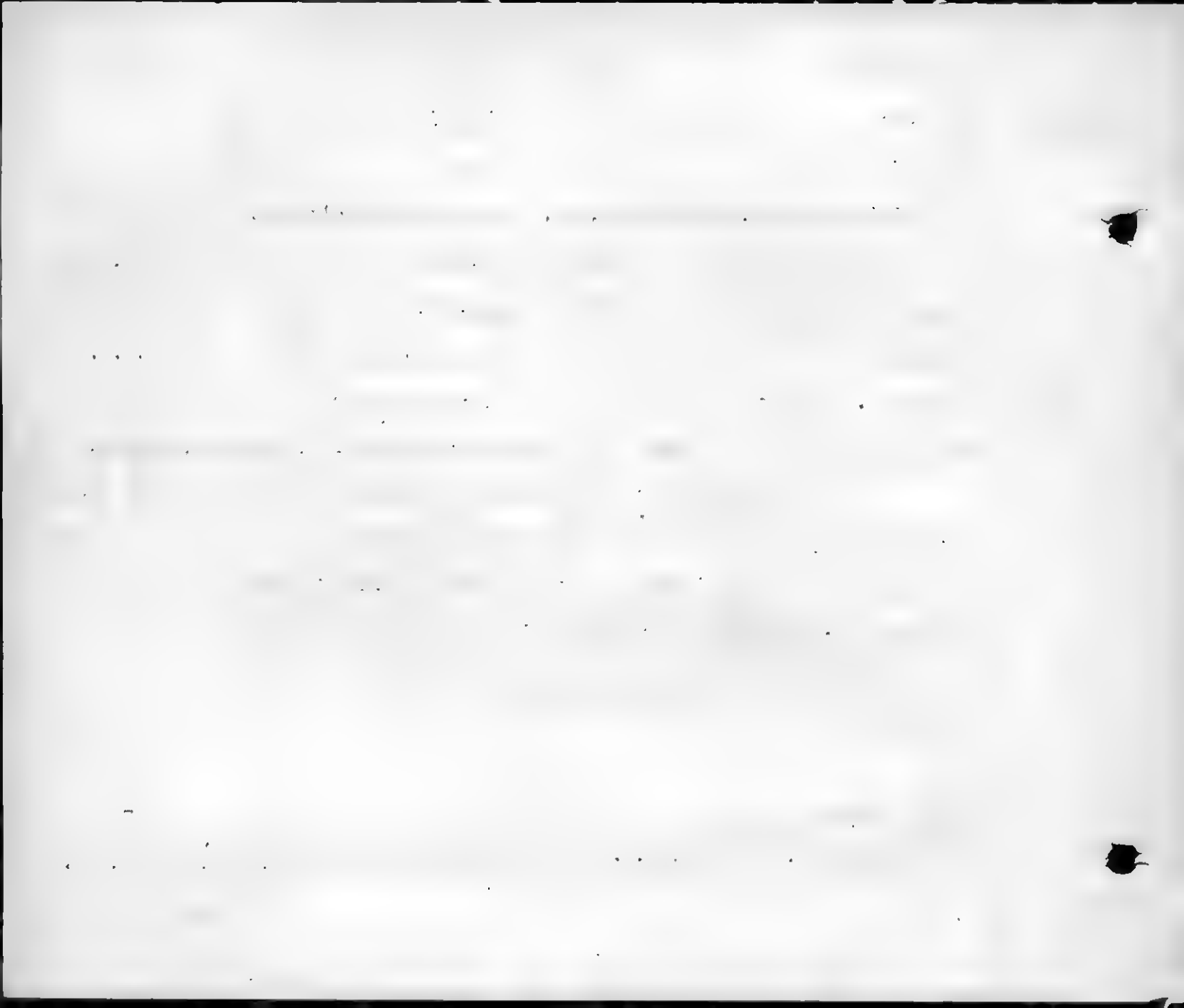
CERTIFICATE OF DEATH

8198

Item 2,267,1-28-60 et

08103

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 23 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Leesburg c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Box 356 d. STREET ADDRESS (Father is Supt. of the Home) Paxton Children's Home		
3. NAME OF DECEASED (Type or print) First James Middle Robert Last Buchanan			4. DATE OF DEATH Month July Day 21 Year 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 10, 1951		9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR: Months 7 Days 22 Hours 0 Min 0
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) California	
13. FATHER'S NAME William R. Buchanan			14. MOTHER'S MAIDEN NAME Eleanor Shaffer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhage and increased Intracranial Pressure. DUE TO (b) Central Nervous System Metastases DUE TO (c) Undifferentiated Small Cell Malignant Tumor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 199.3 INTERVAL BETWEEN ONSET AND DEATH: 2 weeks Unknown 21 Months					
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonitis, Congestive Heart Failure; G I Bleeding					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from June 28, 1960 to July 21, 1960 , that (I) (we) last saw the deceased alive on July 21, 1960 , and that death occurred at 3:45 A. M., from the causes and on the date stated above.					
22a. SIGNATURE Robert B. Scoggins			22b. DATE SIGNED 7-21-60		
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.			22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 23 July 1960		23c. NAME OF CEMETERY OR CREMATORY UNION	
23d. LOCATION (City, town or county) LEESBURG		(State) VA			
24. FUNERAL DIRECTOR'S SIGNATURE MUSE & SONS by Stanley Rud			25a. REC'D BY REGISTRAR JUL 25 '60		25b. REGISTRAR'S SIGNATURE William E. Kneass



FOR STATE
HEALTH DEPT.

TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please secure file certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

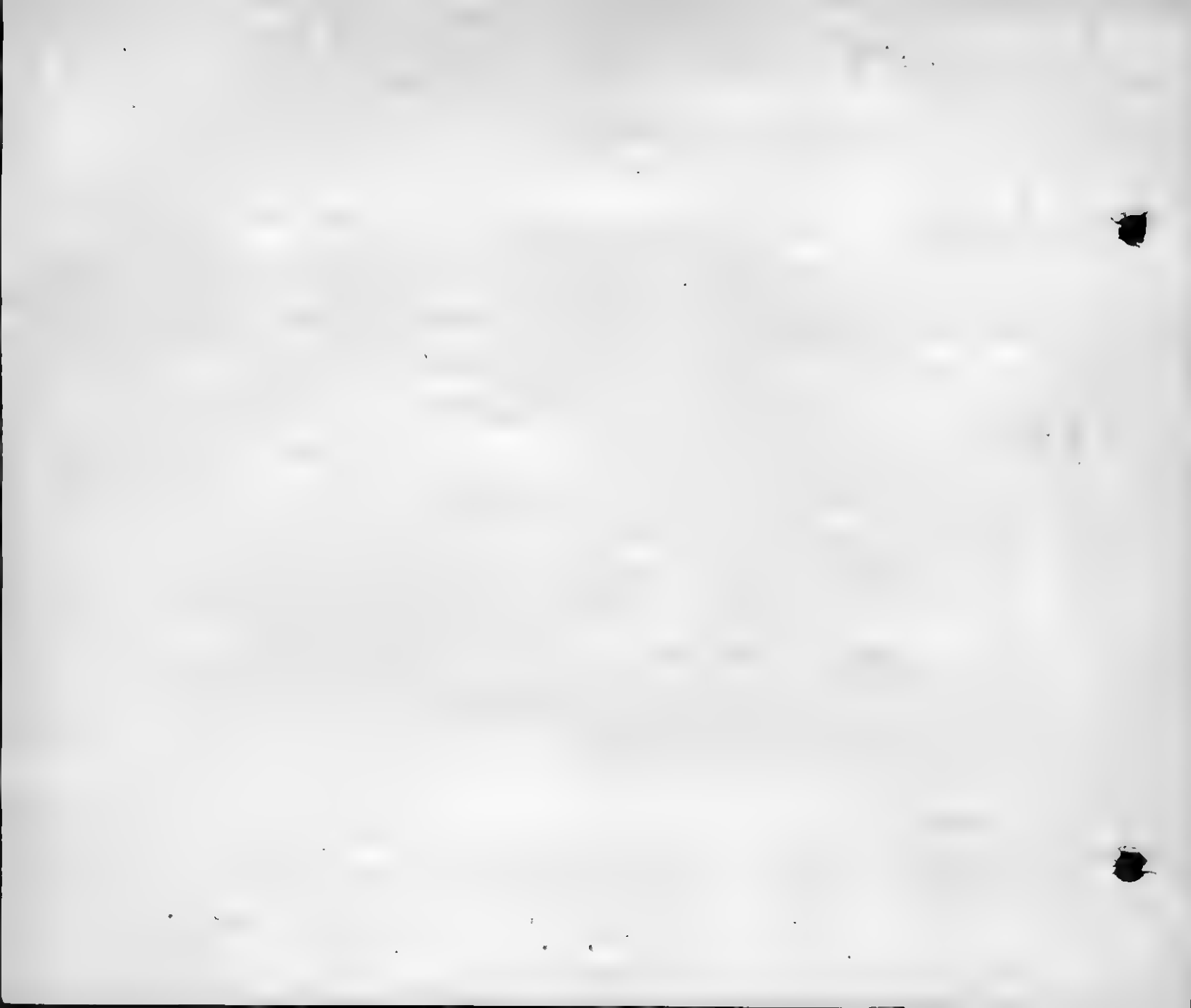
8161

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08164

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
c. LENGTH OF STAY IN 1b <u>life</u>				d. STREET ADDRESS <u>Emory Grove</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Emory Grove</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>Budd</u> Last <u>Budd</u>				4. DATE OF DEATH Month <u>July</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-30-1903</u>	
9. AGE (In years, last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>usa</u>				13. FATHER'S NAME <u>Francis H. Dorsey</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca Brooke</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>Worick H. Budd - Item 2</u>				17. INFORMANT <u>Worick H. Budd - Item 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>420.1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>7-21-60</u>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
<u>Burial</u>		<u>7/24/60</u>		<u>Emory Grove.,</u>		<u>Emory Grove, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Surode</u>				24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kimes</u>	
Address <u>Rockville, Md.</u>							

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

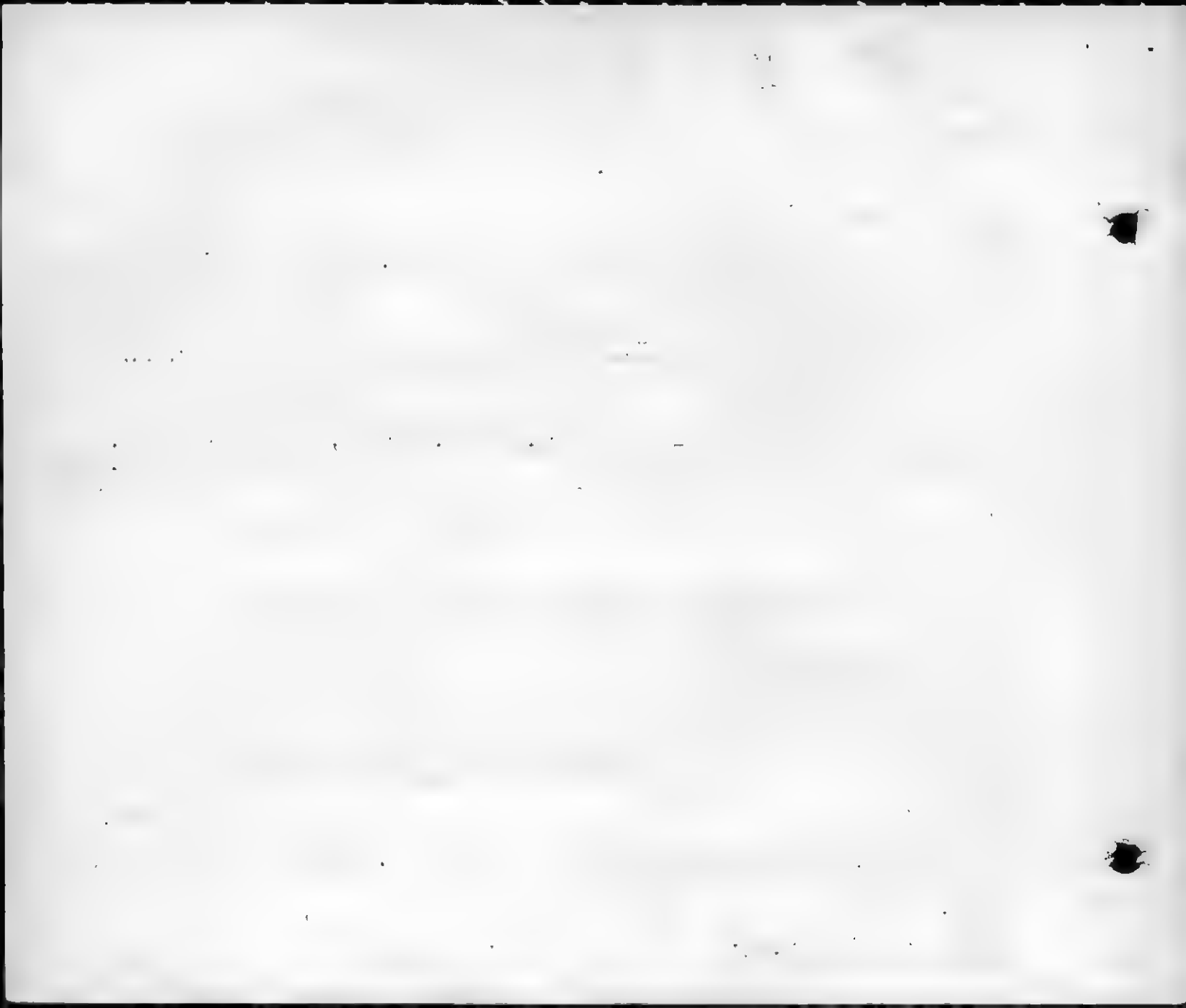
VR A15 (4)
15M 9/59

8109

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08105

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8441 WOODCLIFF COURT		e. STREET ADDRESS 8441 WOODCLIFF COURT	
3. NAME OF DECEASED (Type or print) First LESTER Middle CHARLES Last BURDETT, SR.		4. DATE OF DEATH Month JULY Day 28 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/85
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Self-employed Insurance	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. DECEASED'S NAME FLETCHER BURDETT		14. MOTHER'S MAIDEN NAME SUSAN MANNIX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO 579-446539	
17. INFORMANT Mrs. Mary L. Burdett, 8441 Woodcliff Ct.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CANCER OF THE PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> (b) <input type="checkbox"/> (c) <input type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> o. m. <input type="checkbox"/> p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-3-1954 to 7-28-1960 that (I) (we) last saw the deceased alive on 7-27-1960 , and that death occurred at 2:20 P.M. from the causes and on the date stated above			
22a. SIGNATURE Jerome J. Krick		22b. DATE SIGNED 7/29/60	
22c. PHYSICIAN'S NAME (Type) JEROME J. KRICK		22d. ADDRESS 2800 Quebec Street, N.W.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 7/30/60	
23c. NAME OF CEMETERY OR CREMATORY OAK HILL CEMETERY		23d. LOCATION (City, town, or county) (State) NYACK, NEW YORK	
24. FUNERAL DIRECTOR'S SIGNATURE Raymond A. Giska		25a. REC'D BY REGISTRAR DATE AUG 2 '60	
25b. REGISTRAR'S SIGNATURE Charles S. Hanna		ADDRESS SILVER SPRING, MD.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8110

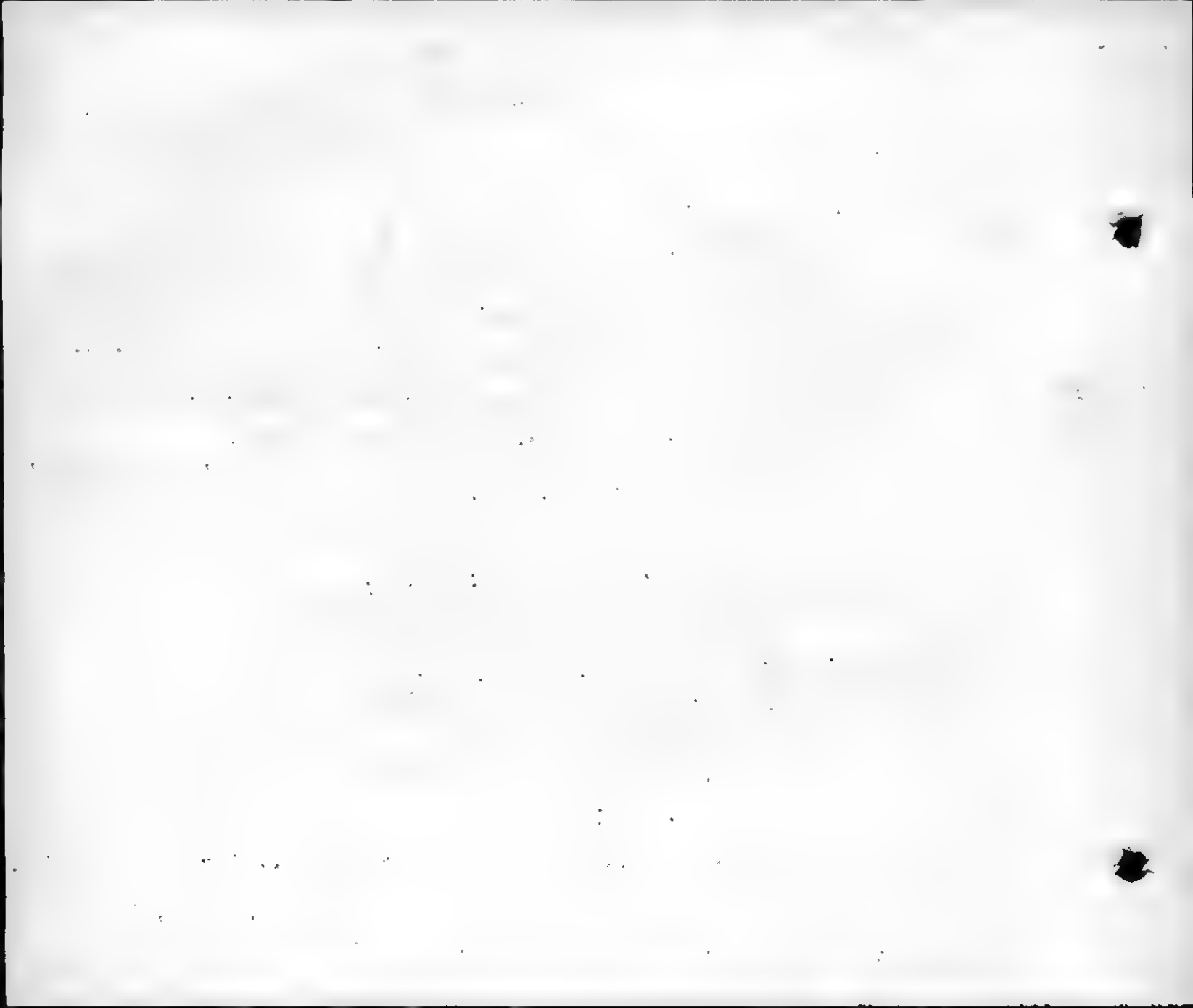
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co</u> <u>Md.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>19149 Sligo Creek Parkway</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Althea Woodland Nursing Home</u>			d. STREET ADDRESS <u>Silver Spring, Md.</u>		
3. NAME OF DECEASED (Type or print) First <u>Jeanette</u> Middle <u>Laura</u> Last <u>Burns</u>			4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>		
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1879</u>	9 AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			13. FATHER'S NAME <u>Jacob Conrad</u>		
14. MOTHER'S MAIDEN NAME <u>Caroline Neuhardt</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO <u>none</u>			INFORMANT <u>Mrs. Raymond Randolph Sanders</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4-50-0</u> IMMEDIATE CAUSE (a) <u>Myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>congestive failure + arteriosclerosis</u> (c) <u>Cachexia & senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9149 Sligo Creek Pkwy, Silver Spring, Md.</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>2 yrs -</u> <u>2 yrs -</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>7/29/60</u>	
21. I certify that I attended the deceased from <u>5-4-1949</u> to <u>7/29/60</u> , that I last saw the deceased alive on <u>7/27/60</u> , and that death occurred at <u>10/35</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive, Silver Spring, Md.</u> DATE SIGNED <u>Norman C. Shoemaker MD.</u>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/1/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	
22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond E. Ziska</u>			
24a. REC'D BY REGISTRAR DATE <u>AUG 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8180

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08167

Item 8 & 9 Film 6207

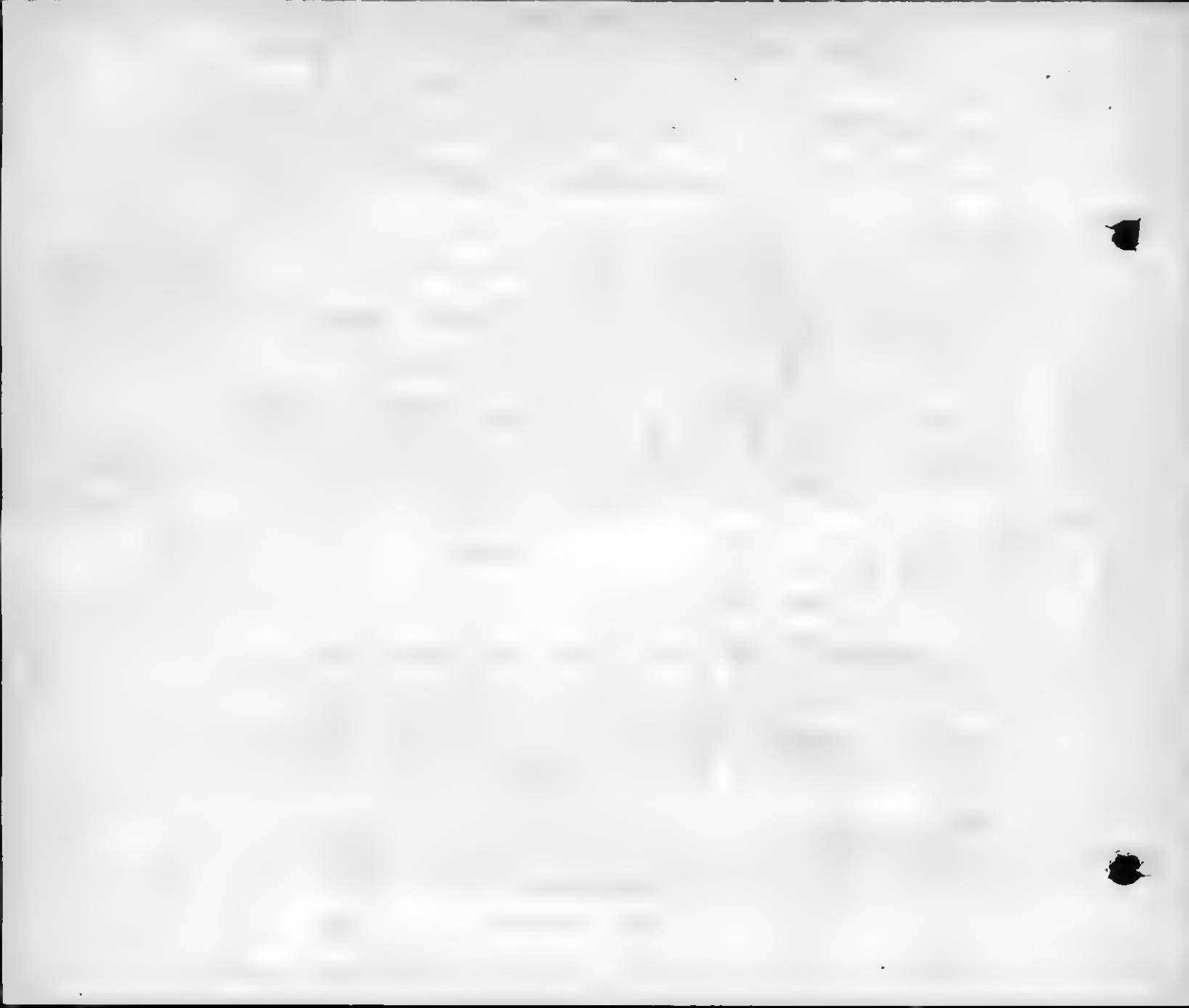
7/15/60 jwk

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 903 Lewis Avenue		e. STREET ADDRESS 903 Lewis Avenue	
3. NAME OF DECEASED (Type or print) First Norman Middle R Last Campbell		4. DATE OF DEATH Month July Day 10 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/29/1895
9. AGE (In years last birthday) 75 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinest	
11. BIRTHPLACE (State or foreign country) Quebec Canada		12. CITIZEN OF WHAT COUNTRY? U/S/A/	
13. FATHER'S NAME Kenneth N Campbell		14. MOTHER'S MAIDEN NAME Isabelle MacDonald	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 008-01-6659	
17. INFORMANT Mrs. Richard Tinsley-daughter-2d		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Sudden			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type) Frank J Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 7/11/60	
22c. NAME OF CEMETERY OR CREMATORY Wilson Cemetery		22d. LOCATION (City, town, or county) (State) Granetville, Vermont	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		24a. REC'D BY REGISTRAR DA 12 '60	
ADDRESS Bethesda, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08108

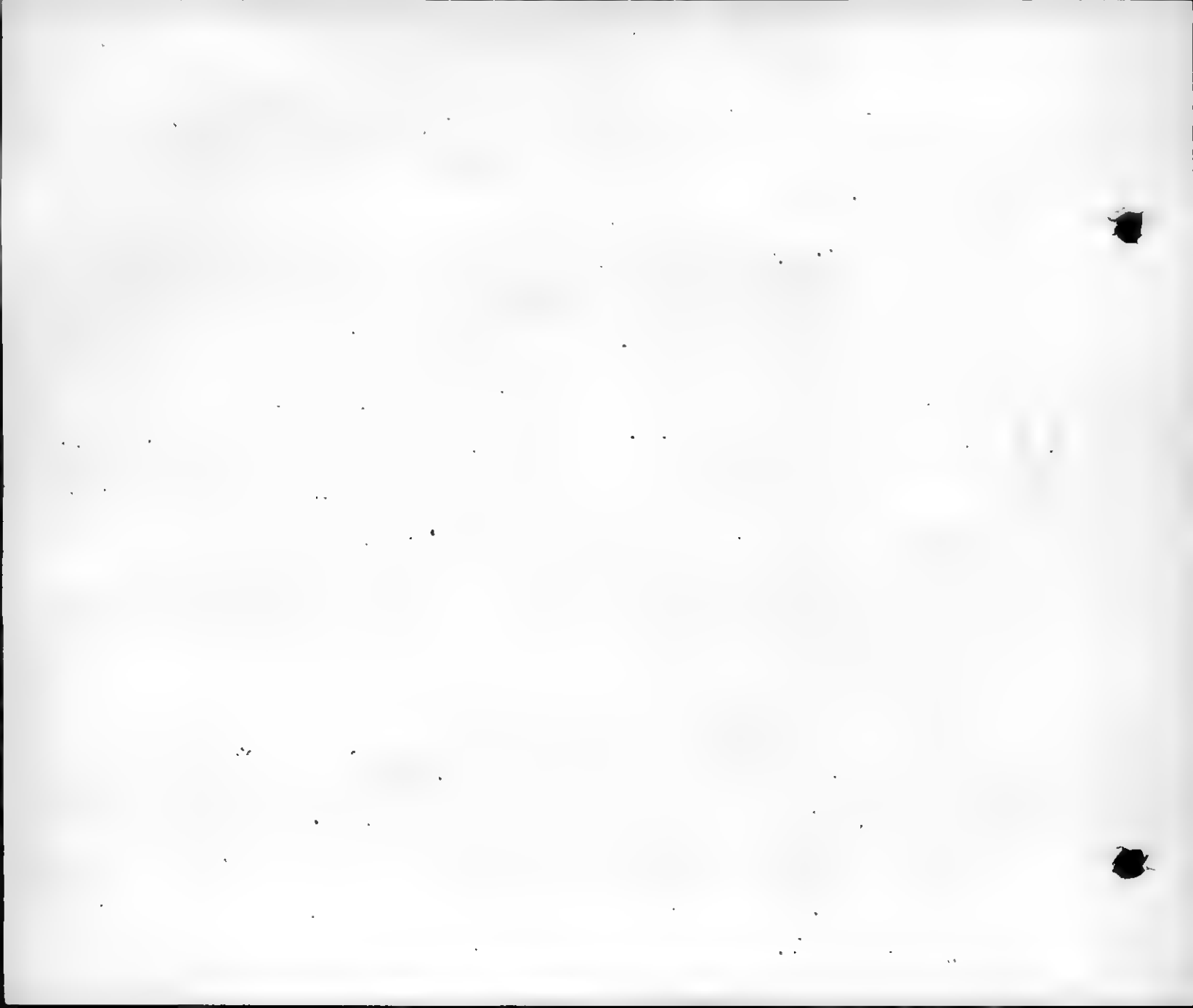
CERTIFICATE OF DEATH

Reg. Dist. No.

8199

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>24 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hypothetum</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nona Brea Catron</u>				4. DATE OF DEATH Month Day Year <u>July 15 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1891</u>		9. AGE (in years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Powell</u>				14. MOTHER'S MAIDEN NAME <u>Smallwood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Rockville, Md.</u> <u>Harvey D. Catron, 5818 Undergriff Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.0</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5 year</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER 1957</u> to <u>JULY 18 1960</u> , that I last saw the deceased alive on <u>JULY 18 1960</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>544 W. MONTGOMERY AVE ROCKVILLE, MD.</u> DATE SIGNED <u>—</u>							
ACTUAL SIGNATURE <u>William Frank</u>		M.D. <u>544 W. MONTGOMERY AVE</u>					
PHYSICIAN'S NAME (Type) <u>William Frank</u>		<u>ROCKVILLE, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Clarksburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Hilton</u>		ADDRESS <u>Baltimore</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

Dr Brochart Modified



may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

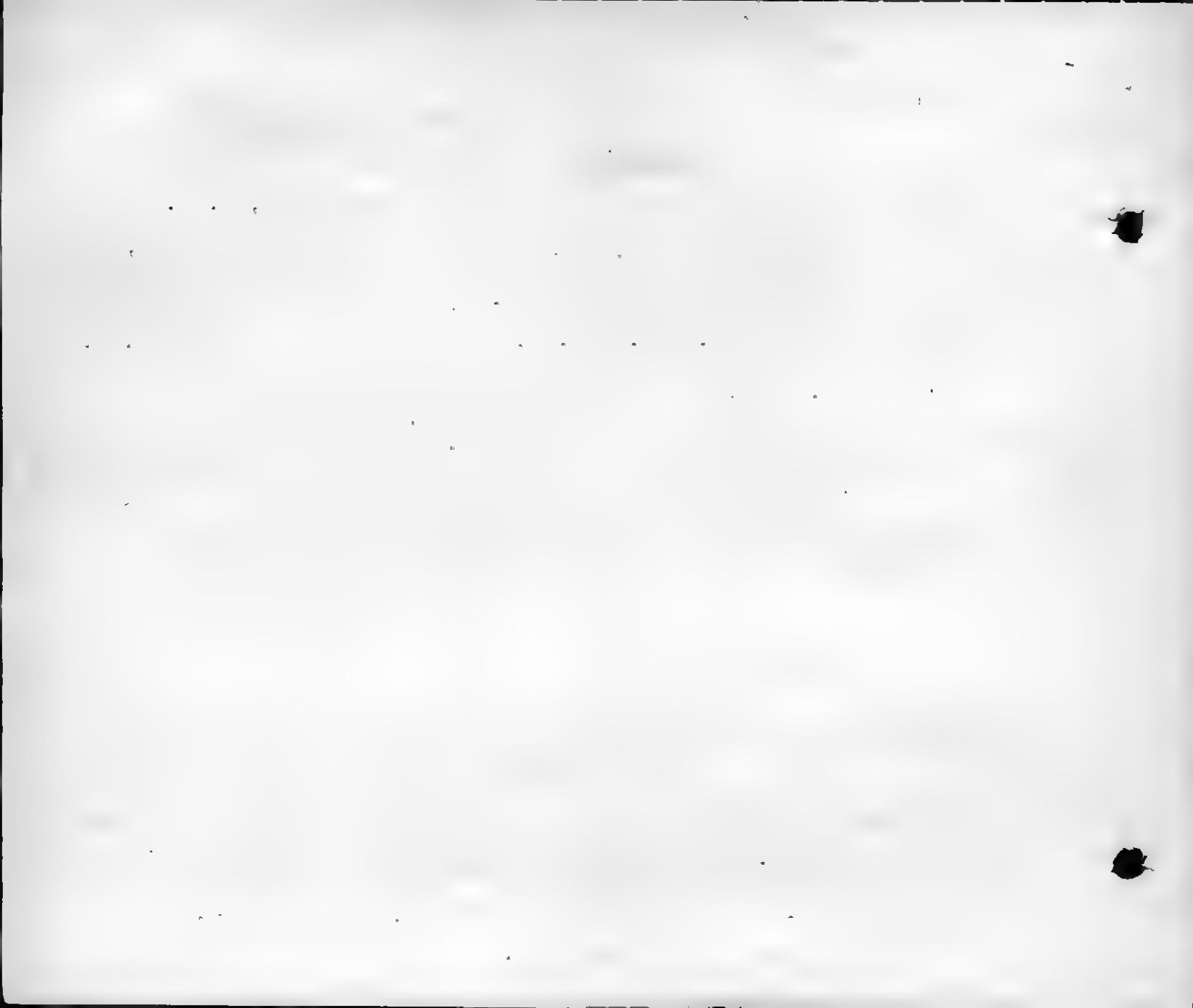
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8181

08109

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. LENGTH OF STAY IN 1b 14 Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Waverly Sanitarium				d. STREET ADDRESS 3639 Windom Place, N. W.			
3. NAME OF DECEASED (Type or print) First ROBERT Middle M. Last CHAPMAN				4. DATE OF DEATH Month July Day 27 , Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1889	
9. AGE (In years last birthday) 70 yrs		10. IF UNDER 1 YEAR Months 11 Days 1		11. IF UNDER 24 HRS Hours Min 		12. CITIZEN OF WHAT COUNTRY? U. S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co.			
11. BIRTHPLACE (State or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Edmund C. Chapman				14. MOTHER'S MAIDEN NAME Annie Boswell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I			
17. INFORMANT Brother				Address Walter G. Chapman Same as Item #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerotic Cardiovascular Dis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Generalized Arteriosclerosis. (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month Day Year 19 Hour a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1956 to July 27, 1960 that (II) (we) last saw the deceased alive on July 20, 1960 and that death occurred at 7 AM , from the cause and on the date stated above.							
22a. SIGNATURE John R. Ewan MD				22b. DATE SIGNED 7-27-60			
22c. PHYSICIAN'S NAME (Type) JOHN R. EWAN				22d. ADDRESS 1835 Eye St. N.W. Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial-transit 7-29-60		7-29-60		Tabernacle Church Cem.		Arthursville, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY				25a. REC'D BY REG STRAR DATE JUL 28 '60			
ADDRESS Bethesda, Md.				25b. REGISTRAR'S SIGNATURE John R. Ewan			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08110

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 803 GREGORIO DRIVE				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 803 GREGORIO DRIVE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM GEORGE CHIPPAS		4. DATE OF DEATH JULY 21 1960		5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 1, 1900		9. AGE (in years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours M.n. 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER RESTAURANT		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE WILLIAM CHIPPAS		14. MOTHER'S MAIDEN NAME Olga unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-10-2886	
17. INFORMANT Mrs. Lila Mae Chippas		Address 803 Gregorio Drive Silver Spring, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) History of previous heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
21. ACTUAL SIGNATURE Frank J. Broschart		21. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		21. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 7/21/60	
21. EXAMINER'S NAME (Type) FRANK J. BROSCART		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/23/60	
22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND		23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC.		23. ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR JUL 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hinkle		24c. REGISTRAR'S NAME		24d. REGISTRAR'S ADDRESS	

MEDICAL CERTIFICATION

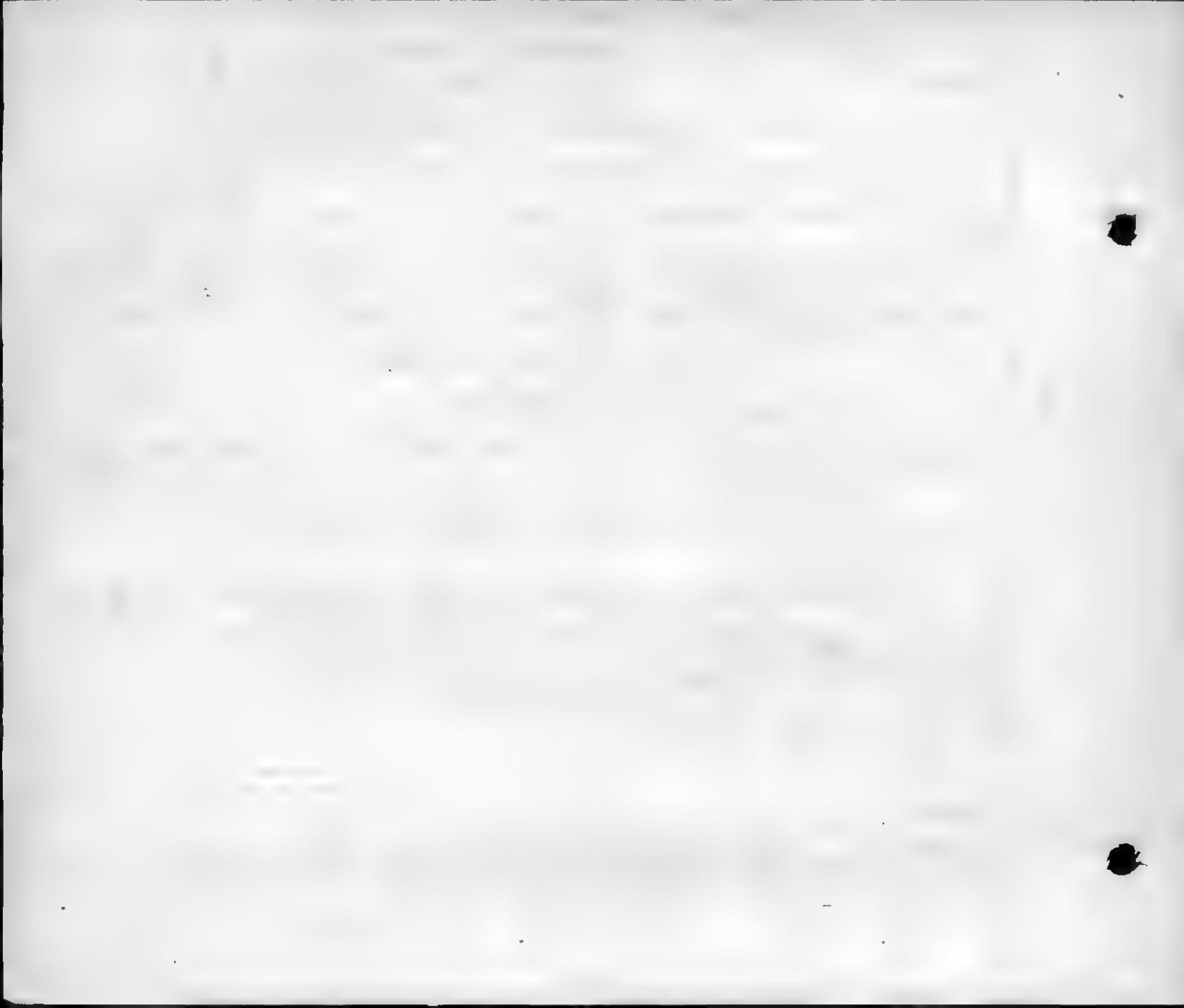
8112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>11 years</i>		d. STREET ADDRESS <i>62111 Spencer Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2111 Spencer Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lee Ross Christensen</i>		4. DATE OF DEATH <i>July 13 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/17/90</i>
9. AGE (In years last birthday) <i>70 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS Month <i>5</i> Days <i>26</i> Hours <i></i> Min <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lawyer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Legal</i>	
11. BIRTHPLACE (State or foreign country) <i>Utah</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>	
13. FATHER'S NAME <i>J. W. Christensen</i>		14. MOTHER'S MAIDEN NAME <i>Simpson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes WW I & 2</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Virginia Rebuttle</i>		Address <i>Boston Mass.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic carcinoma</i> 1-3-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of colon</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>-</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>None</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/28, 1960</i> to <i>present</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>7/13</i> , 19 <i>60</i> , and that death occurred at <i>11:55</i> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8805 CORNW. AVE.</i> DATE SIGNED <i>7/13/60</i>			
ACTUAL SIGNATURE <i>John B. Umhau</i> M.D.		PHYSICIAN'S NAME (Type) <i>John B. Umhau</i> <i>CHEY CHASE 15 MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-18-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>ROBERT A. PUMPHREY</i>		ADDRESS <i>Bethesda, Md.</i>	
24a. REC'D BY REGISTRAR <i>JUL 15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08112

8200

1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sellman - RFD
c. LENGTH OF STAY IN 1b 60 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sellman - RFD
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)
First Ernest Middle F Last Claggett
4. DATE OF DEATH Month July Day 22 Year 1960

5. SEX M 6. COLOR OR RACE Colored 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH March 22 - 1893 9. AGE (In years, last birthday) 67 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer 10b. KIND OF BUSINESS OR INDUSTRY Maryland 11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Claggett 14. MOTHER'S MAIDEN NAME Edmonia Ambush

15. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown (If yes give war or defense service) No 16. SOCIAL SECURITY NO. 211-127063 17. INFORMANT Bessie Claggett, Barnesville Md Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion -
DUE TO
Conditions, if any, which gave rise to immediate cause (b) Cardio Vascular disease -
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

ACTUAL SIGNATURE John B. Ball M.D. DATE SIGNED 22 July 60
EXAMINER'S NAME (Type) CARVER MEMORIAL PARK CEM.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 7/25/60 22c. NAME OF CEMETERY OR CREMATORY St. Mary's 22d. LOCATION (City, town, or country) (State) Barnesville Md.

23. FUNERAL DIRECTOR William B. Hillen Barnesville, Md ADDRESS Barnesville, Md 24a. REC'D BY REGISTRAR JUL 26 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus



1
FOR STATE
HEALTH DEPT.

TO DETECT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08113

8201

1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson R7N
c. LENGTH OF STAY IN 1b 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) White Ferry

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE md b. COUNTY Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 300 Adams Rd
d. STREET ADDRESS Frederick md

3. NAME OF DECEASED (Type or print) Jesse Lee Clark
4. DATE OF DEATH July 3 1960
5. SEX male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 2-22-1921 9. AGE (In years last birthday) 39 yrs. IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS. Months Days Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) chaperon 10b. KIND OF BUSINESS OR INDUSTRY md. harystatn co 11. BIRTHPLACE (State or foreign country) md 12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME William H. Clark 14. MOTHER'S MAIDEN NAME Clara Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW2 16. SOCIAL SECURITY NO. 220-05-1359 17. INFORMANT Mrs Dale Carter - 302 Adams Rd, Frederick md Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

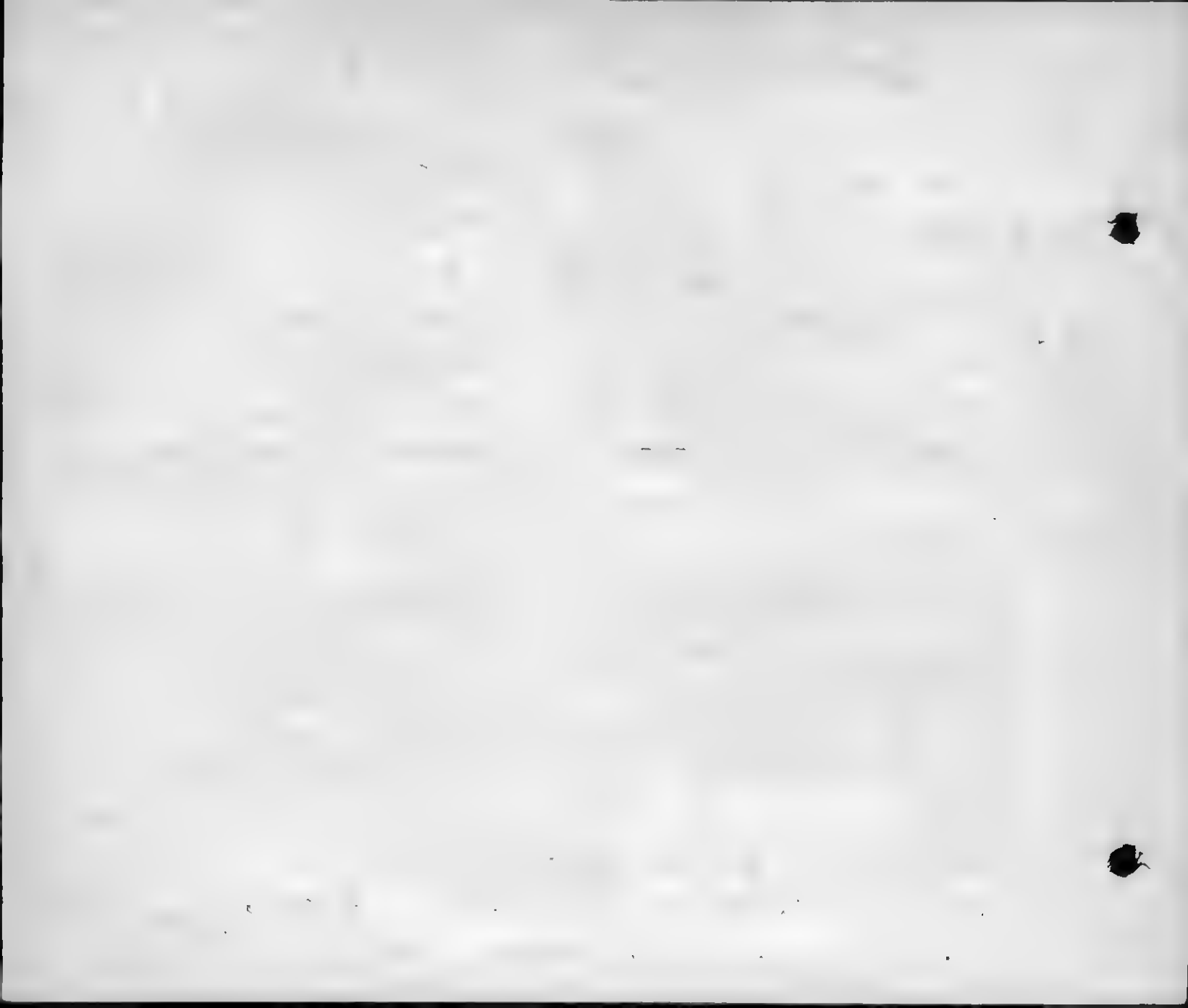
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschant CHIEF MEDICAL EXAMINER ☐ M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 7-3-60
EXAMINER'S NAME (Type) FRANK J. Broschant Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF July 7, 1960 22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery 22d. LOCATION (City, town, or county) (State) Frederick, Maryland

23. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Maryland ADDRESS 24a. REC'D BY REGISTRAR Jul 5 '60 24b. REGISTRAR'S SIGNATURE Arthur L. Kline

MEDICAL CERTIFICATION



101
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Filed 2-20-60										MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08114																													
8202										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.																													
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN 1b DOA					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda					d. STREET ADDRESS 9710 Montank Ave.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																													
3. NAME OF DECEASED (Type or print) Adelbert J. Cole					4. DATE OF DEATH July 16, 1960					5. SEX male					6. COLOR OR RACE white					7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH May 4, 1910					9. AGE (In years last birthday) 50 yrs.					10. IF UNDER 1 YEAR Months Days					11. IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beau. of Standards										10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.										11. BIRTHPLACE (State or foreign country) Ohio										12. CITIZEN OF WHAT COUNTRY? USA																			
13. FATHER'S NAME James A. Cole										14. MOTHER'S MAIDEN NAME Myrtle Cole										15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.										17. INFORMANT Sarah B. Cole Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Thrombosis DUE TO (c)																				INTERVAL BETWEEN ONSET AND DEATH																													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Reported to have taken ant poison (Cyanogas)																																							
20c. TIME OF INJURY Month, Day, Year Hour 7:16/60 p. m.										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home										20f. (City or town) Bethesda (County) Montg. Md. (State)																			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> / Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>																																																	
ACTUAL SIGNATURE Frank J. Broschart										M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 7/17/60																													
EXAMINER'S NAME (Type) Frank J. Broschart										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 7-20-60										22c. NAME OF CEMETERY OR CREMATORY Arlington National										22d. LOCATION (City, town, or county) Reston, Va. (State)																			
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home										ADDRESS Washington D.C./										24a. REC'D BY REGISTRAR JUL 19 60										24b. REGISTRAR'S SIGNATURE Arthur S. Thomas																			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any case not later than 72 hours after death.

VR A15 (4)
15M 9/59

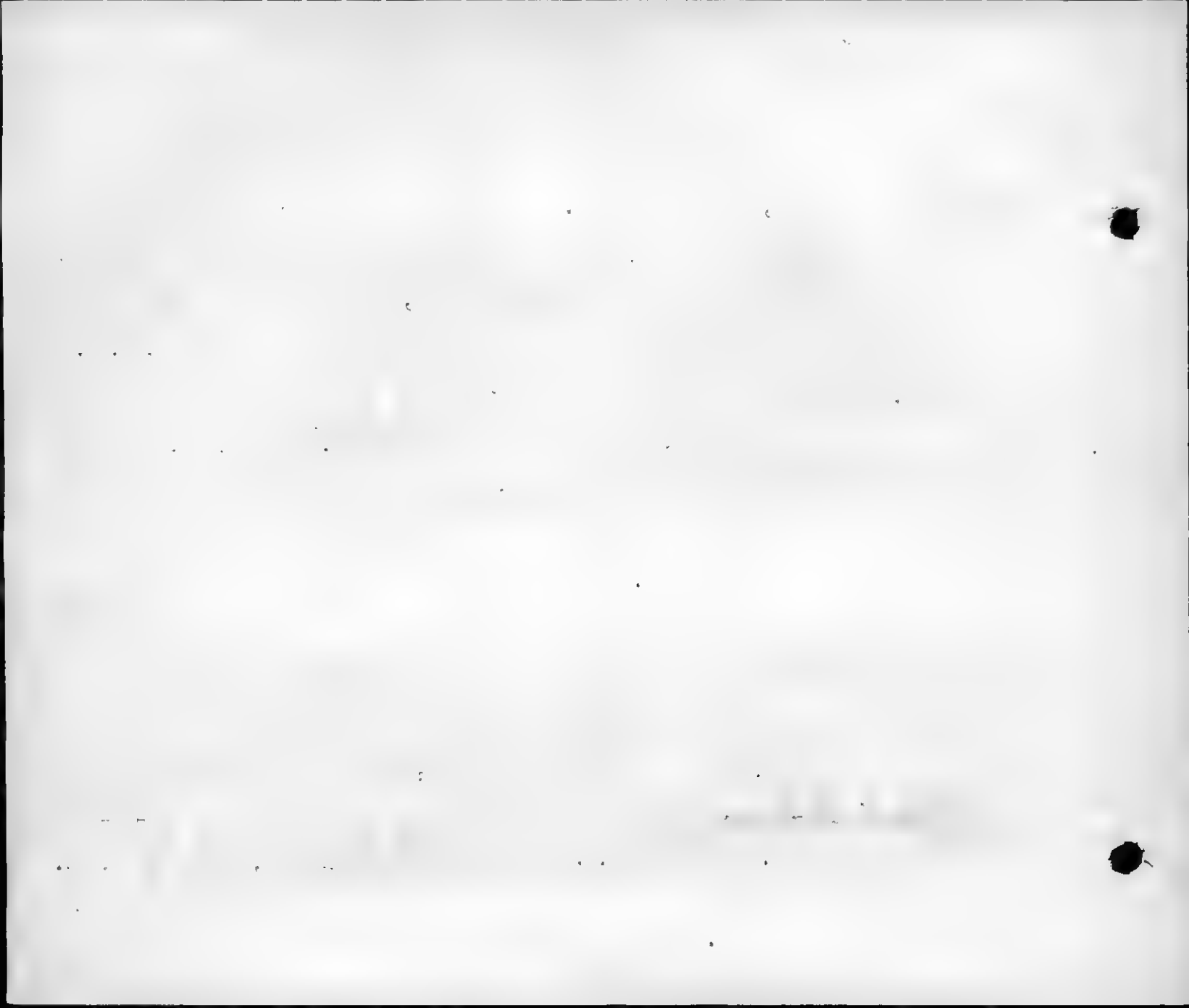
8203

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08115

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Florida b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 7 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tampa 4,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			d. STREET ADDRESS 515 East 128th Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ronnie Middle Jax Last Collier			4. DATE OF DEATH Month July Day 30 Year 19 60		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 13, 1960		9. AGE (In years last birthday) 5 yrs. IF UNDER 1 YEAR Months 5 Days 17 IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Florida	
13. FATHER'S NAME Ralph E. Collier			14. MOTHER'S MAIDEN NAME Christine Ray		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Thrombocytopenia DUE TO (c) Acute Myelogenous Leukemia					INTERVAL BETWEEN ONSET AND DEATH Days Unknown 3 weeks
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from July 23 19 60 to July 30 19 60 that (I) (we) last saw the deceased alive on July 30 19 60 and that death occurred 1:35 P.M. at the causes and on the date stated above					
22a. SIGNATURE Robert B. Scoggins		M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 7-30-60	
22c. PHYSICIAN'S NAME (Type) ROBERT B. SCOGGINS, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) SHIP RR.		23b. DATE THEREOF 7-31-60		23c. NAME OF CEMETERY OR CREMATORY GLENNVILLE, GA.	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers		ADDRESS 1400 Chapin St N.W.		25a. REC'D BY REGISTRAR AUG 3 '60	
25b. REGISTRAR'S SIGNATURE Charles E. House					

7 VVVVVVVXVV



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08116

8204

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 7508 Dunston St.			
3. NAME OF DECEASED (Type or print) First Middle Last Dorothy Freeman CONNOR				4. DATE OF DEATH Month Day Year July 19 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-97	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas FREEMAN				14. MOTHER'S MAIDEN NAME ELLEN JONES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sclerosis, amyotrophic lateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 12 1960 to July 19 1960 , that (I) (we) last saw the deceased alive on July 19 1960 , and that death occurred at 2:50 PM from the causes and on the date stated above.							
22a. SIGNATURE M. E. Allison, Jr.				22b. DATE SIGNED 7-19-60		22c. PHYSICIAN'S NAME (Type) M. E. ALLISON, JR., LCDR, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATON REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-20-60		23c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery		23d. LOCATION (City, town, or county) (State) Belmont Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE Jos. Gawler's & Sons, 1756 Penn. Ave. NW, Wash DC				25a. REC'D BY REGISTRAR DATE JUL 25 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. Page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

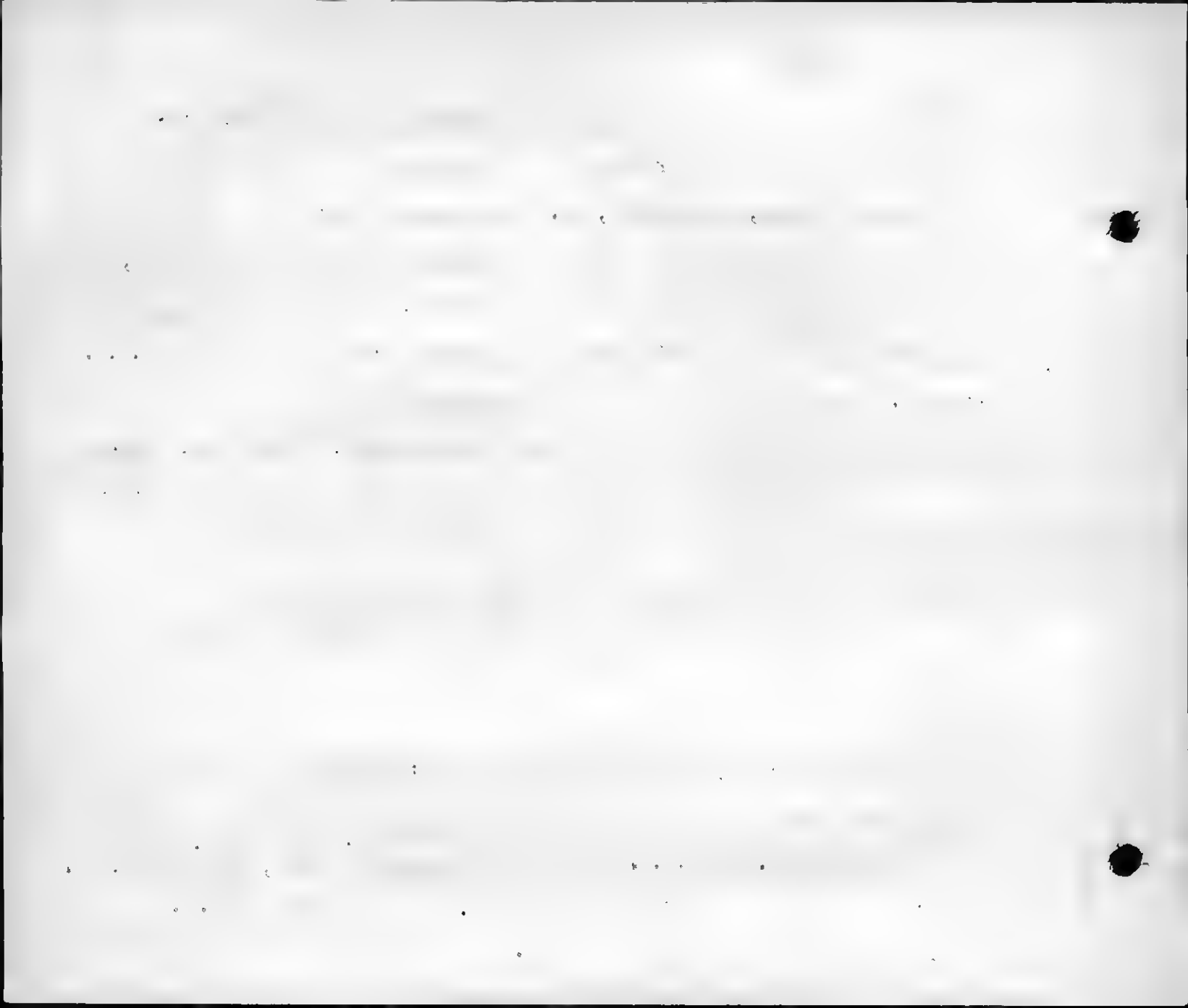


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8205 CERTIFICATE OF DEATH 08117

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 28 days d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) The Clinical Center, Bethesda 14, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Saint Marys c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California d. STREET ADDRESS No street address e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Aucil Last Cooper		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 3, 1873
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsmen		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James C. Cooper		14. MOTHER'S MAIDEN NAME Rachel Hensley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420 DUE TO (b) Coronary Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A POSTMORTEM PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 7 1960 to July 5 1960 , that (I) (we) last saw the deceased alive on July 5 1960 , and that death occurred at 5:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Michael J. Lazor M.D.		22b. DATE SIGNED 7/6/60	
22c. PHYSICIAN'S NAME (Type) Michael J. Lazor, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/8/60	
23c. NAME OF CEMETERY OR CREMATORY Valley Town Cem.		23d. LOCATION (City, town, or county) (State) Andrews, N.C.	
24. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		25a. REC'D BY REGISTRAR DATE JUL 8 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



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8169

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08118

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>2700 Wisconsin Avenue NW</u>	
3. NAME OF DECEASED (Type or print) <u>KATHERINE HAMILTON CORBIN</u>		4. DATE OF DEATH <u>JULY 18 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 December 1872</u>
9. AGE (In years last birthday) <u>87</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>LOUISIANA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Hamilton</u>		14. MOTHER'S MAIDEN NAME <u>JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Mrs. Emily Cole (daughter)</u>		Address <u>2700 Wisconsin Ave. Washington, D.C. NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension</u>			<u>6 hours</u>
DUE TO (b) <u>Cerebral thrombosis</u>			<u>3 days</u>
DUE TO (c) <u>Cerebral arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>July 18</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>July 18</u> , 19 <u>60</u> , and that death occurred at <u>9:58 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred Baer, M.D.</u>		22b. DATE SIGNED <u>July 18, 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>ALFRED BAER, M.D.</u>		22d. ADDRESS <u>2713 Wisconsin Avenue NW Washington 7, D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/23/60</u>	<u>Forest Hill Cemetery</u>	<u>Prince Georges County Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Charles Fred Home</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 22 '60</u>	
ADDRESS <u>5100 Phoenicia Ave. Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Home</u>	



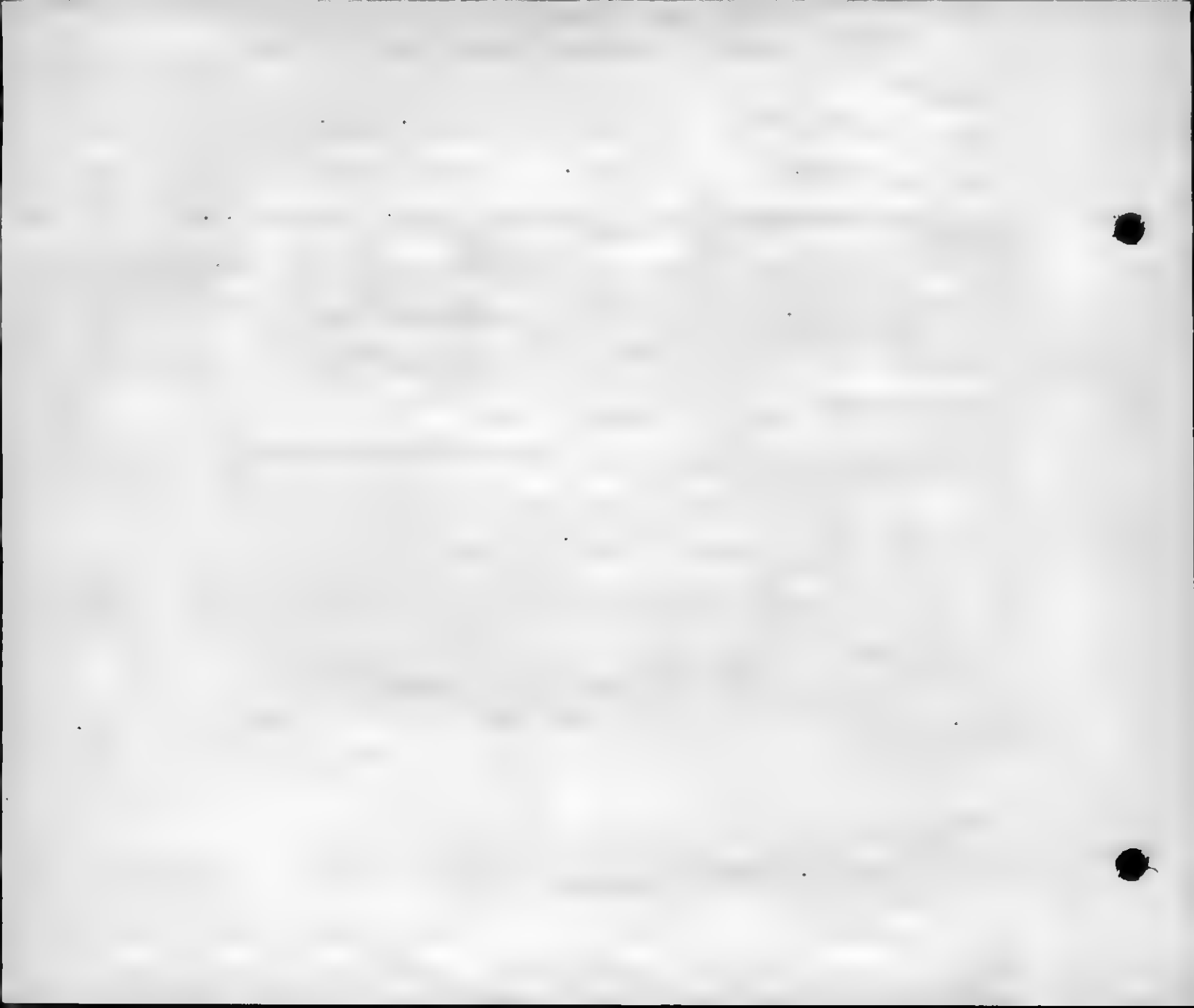
TO DEPUTY MEDICAL EXAMINER: This certificate shall be examined within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 081119

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Dist. of Co. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 6 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C.			
				d. STREET ADDRESS 1019-16 th. St. N.E.			
3. NAME OF DECEASED (Type or print) First John Middle Crawford Last				4. DATE OF DEATH Month July Day 12 Year 1960			
5. SEX Male		6. COLOR OR RACE Col.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1909	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 51 Days 12 Hours 19 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab orer				10b. KIND OF BUSINESS OR INDUSTRY Construction			
11. BIRTHPLACE (State or foreign country) South Carolina				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Crawford				14. MOTHER'S MAIDEN NAME Hattie (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT Ethel Crawford- Same as Above Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed in a cave-in 910.8 DUE TO Crushed Chest & Ruptured Liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Compression by Cave-in INTERVA. BETWEEN ONSET AND DEATH 1 hour 1 hour							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed in a cave-in on a construction job			
20c. TIME OF INJURY Month, Day, Year 11:57 a.m. 7/12/60				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) construction job	
				20f. (City or town) Silver Spring (County) Montg. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Frank J. Broschart				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 7/13/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) 7-16-60		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) Concepcion (State) S.C.	
23. FUNERAL DIRECTOR'S SIGNATURE Travis Funeral Home, 384 R.D. Ave. N.W.				24a. REC'D BY REGISTRAR DAVID 18 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

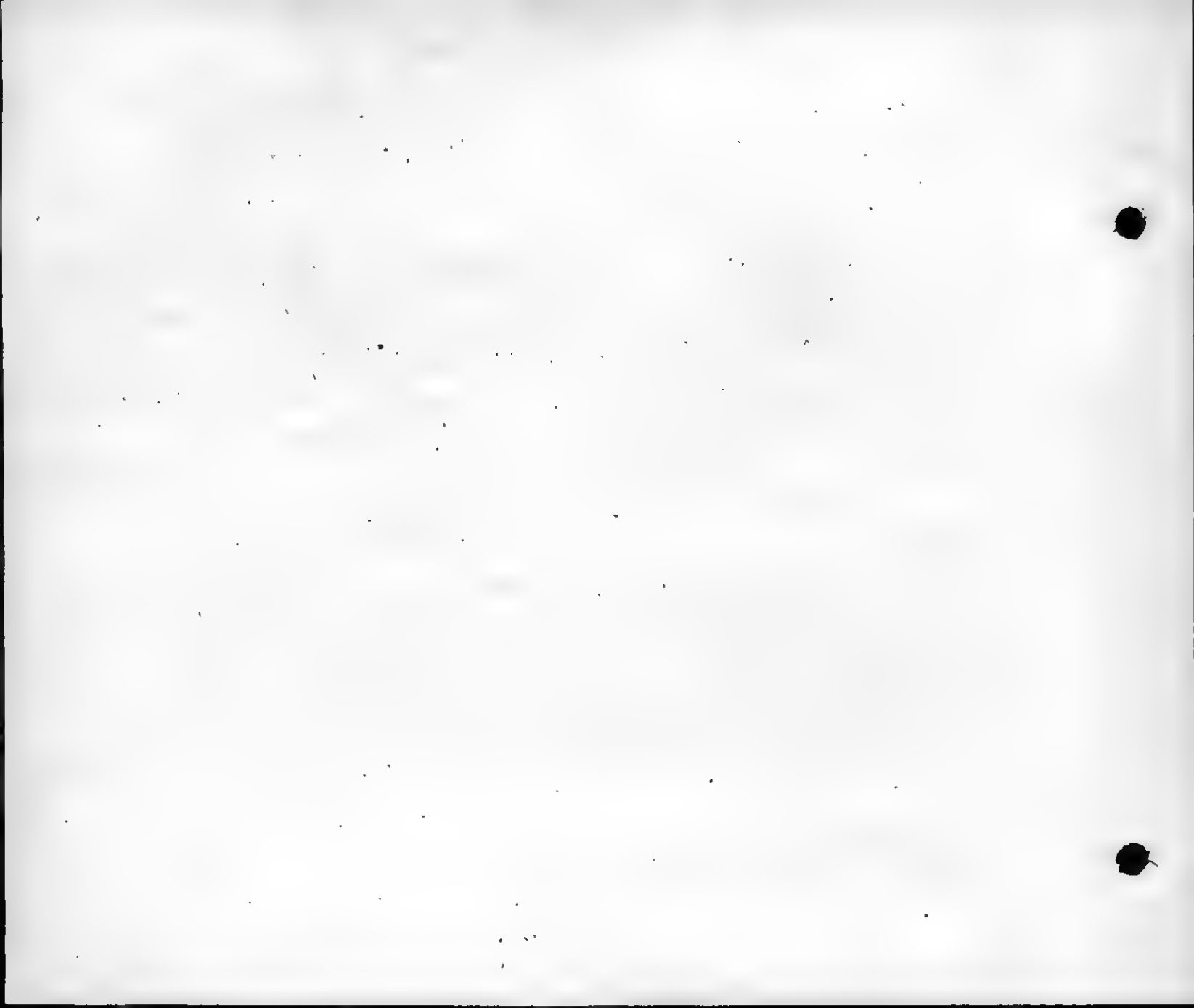
8207

CERTIFICATE OF DEATH

Reg. Dist. No.

08120

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Norbeck</u>		c. LENGTH OF STAY IN 1b <u>3 wks.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Everest Care Home</u>		e. STREET ADDRESS <u>5615 - 30th Ave 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Nelson</u> Middle <u>Hines</u> Last <u>Crouch</u>		4. DATE OF DEATH Month <u>July</u> Day <u>20th</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3, 1898</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.B. & O. R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Kent County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Crouch</u>		14. MOTHER'S MAIDEN NAME <u>Annie Ireland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>579-095335</u>	
17. INFORMANT <u>Samuel N. Crouch, son</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Infectious Dermatitis + Decubitus</u> (c) <u>Sclerosis + senile inactivity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Floor <u> </u> a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that I attended the deceased from <u>July 5, 1960</u> to <u>July 20, 1960</u> , that I last saw the deceased alive on <u>July 20, 1960</u> , and that death occurred at <u>11:40</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.		ADDRESS (Street, city or town, state) <u>Norbeck</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>		DATE SIGNED <u>7-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/23/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home, Inc.</u>		24a. REC'D BY REGISTRAR <u>Mt. Rainier Md.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>
DATE <u>JUL 25 '60</u>		DATE <u>JUL 25 '60</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08121

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		d. STREET ADDRESS 11613 Dewey Road	
3. NAME OF DECEASED (Type or print) First Jack Middle Owen S Last Crowe		4. DATE OF DEATH Month 7 Day 1 Year 1960	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/39
9. AGE (In years last birthday) 29 yrs.		10. IF UNDER 1 YEAR Months 25 Days 1	
11. IF UNDER 24 HRS Hours 1 Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gasoline Station		10b. KIND OF BUSINESS OR INDUSTRY Manager	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Gurney C. Crowe		14. MOTHER'S MAIDEN NAME Irene Resh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-8688	
17. INFORMANT Ellen M. Crowe		Address 11613 Dewey Road, Silver Spring Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral Hemorrhages DUE TO 315.6 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exacerbated Contractions & Lacerations DUE TO 10 hours (c) Multiple Skull Fractures 10 hours PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Putting air in tire which exploded striking him in face			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Putting air in tire which exploded striking him in face	
20c. TIME OF INJURY Month, Day, Year 7/1/60 Hour 7:05 a. m. PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Viers Mill Esso		20f. (City or town) Silver Spring Montg. (County) Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschatt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschatt		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/5/60	
22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Park		22d. LOCATION (City, town, or county) Cumberland Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR JUL 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8209

08122

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN lb 20 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ASHTON d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First THOMAS Middle JEANETTE Last CUFF				4. DATE OF DEATH Month JULY Day 27 Year 19 60									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/89		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 27 Days 27 Hours 19 Min. 60			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS R. JOHNSON						14. MOTHER'S MAIDEN NAME MARY ISABELLE TUCKER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. -				17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Hemorrhagic Pancreatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) also - Chronic Nephritis DUE TO (c) -										INTERVAL BETWEEN ONSET AND DEATH 3 wks yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Oct 19 59 to 7/27 19 60, that (I) (we) last saw the deceased alive on 7/27 19 60, and that death occurred on 7/27 19 60, from the causes and on the date stated above.													
22a. SIGNATURE Charles H. Ligon, M.D.						22b. DATE SIGNED 7/28/60							
22c. PHYSICIAN'S NAME (Type) CHARLES H. LIGON, M. D.						22d. ADDRESS SANDY SPRING, MD.							
23a. BURIAL, CREMATION, or other disposition BURIAL				23b. DATE THEREOF 7-30-60		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION (City, town, or county) (State) Burtonsville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber						ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR DATE AUG 2 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Hines			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

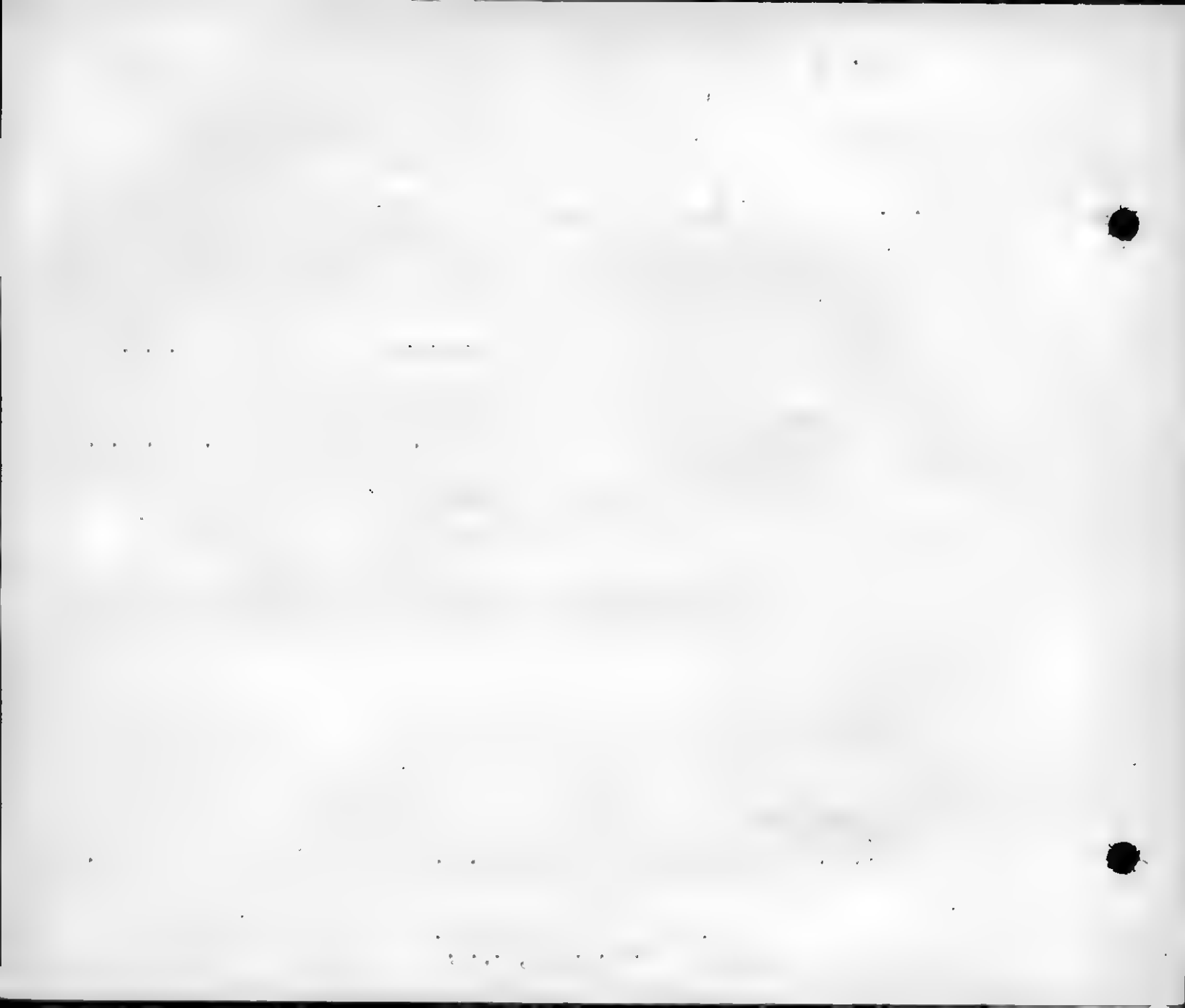
VR AIS (4)
15M 9/59

1
8210

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08123

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
				d. STREET ADDRESS 4222 Massachusetts Avenue			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Thornton Middle Roosevelt Last Curry				4 DATE OF DEATH Month July Day 16 Year 1960			
5 SEX Male	6 COLOR OR RACE Negroid	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 22, 1922	9 AGE (In years last birthday) yrs. 38	IF UNDER 1 YEAR: Months Days Hours	IF UNDER 24 HRS: Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Virginia	
						12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Otho Curry				14 MOTHER'S MAIDEN NAME Bessie Lewis			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes 1943 - 1946		16 SOCIAL SECURITY NO		17 INFORMANT Mattie J. Curry Address 4222 Mass. Ave. S.E. WDC			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain lesion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19 WAS A JTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 14 0600 AM 1960 to July 16 1960 , that (I) (we) last saw the deceased alive on July 16 1960 , and that death occurred at M , from the causes and on the date stated above.							
22a SIGNATURE J. H. Miller				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 7-16-60	
22c PHYSICIAN'S NAME (Type) J. H. MILLER, LT MC USN				22d ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a BURIAL, CREMATION REMOVAL (Specify) Burial		23b DATE THEREOF 7-20-60		23c NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d LOCATION (City, town or county) (State) Arlington, Virginia	
24 FUNERAL DIRECTOR'S SIGNATURE Robert L. Plummer, Rhines & Co.				25a REC'D BY REGISTRAR Warriss Funeral Home		25b REGISTRAR'S SIGNATURE Arthur L. Plummer	
				DATE JUL 19 '60			



13
1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8134

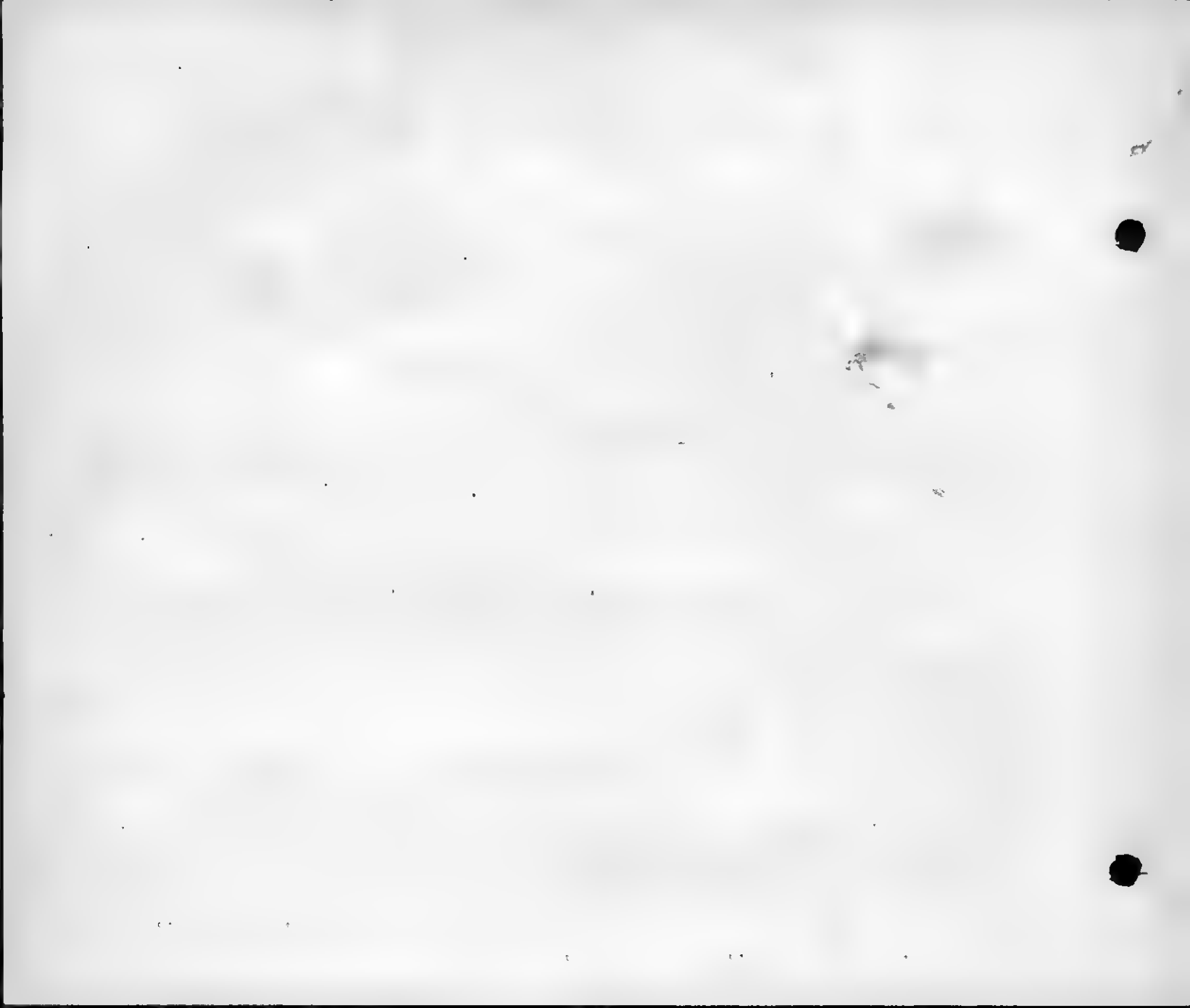
CERTIFICATE OF DEATH

Reg. Dist. No.

08124

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>1 month</u>		d. STREET ADDRESS <u>733 North Hampton Drive</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lucille Dorothy Dahms</u>		4. DATE OF DEATH Month Day Year <u>July 10 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 17, 1912</u>
9. AGE (In years lost birthday) yrs <u>48</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Therapist for a Psychiatrist</u>		11. BIRTHPLACE (State or foreign country) <u>Oklahoma</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Dodds</u>	
14. MOTHER'S MAIDEN NAME <u>Opal E. Wollery</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>447-229-275</u>		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>15257</u> DUE TO <u>Carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>General abdominal carcinomatosis</u> DUE TO <u>Carcinoma large bowel & ovary</u> (c) <u>10 days</u> 3 months 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/10</u> , 19 <u>60</u> , to <u>7/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/9</u> , 19 <u>60</u> , and that death occurred at <u>6:40 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>7600 Carroll Ave - Th. Ok.</u> ACTUAL SIGNATURE <u>John F. Brownberger M.D.</u> PHYSICIAN'S NAME (Type) <u>John F. Brownberger</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 15, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW CHICKASHA CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>CHICKASHA, GRADY CO., OKLAHOMA</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Warner E. Humphrey Inc. Silver Spring, Maryland</u> <u>Raymond C. Gaska</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 14 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon copy of page 1 and file it in the registrar's office.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

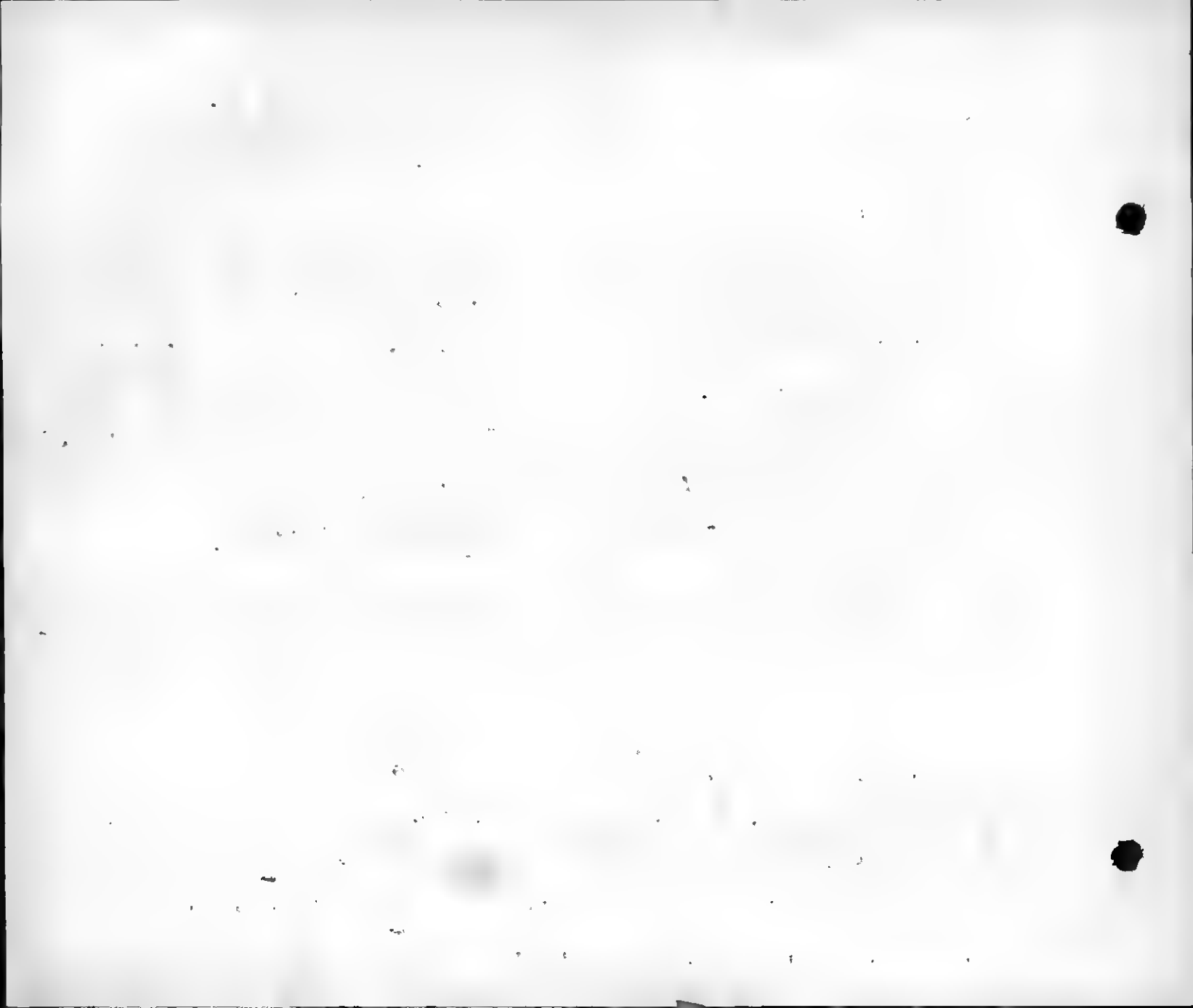
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08125

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN 1b X Gaithersburg			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Ammons Nursing Home				e. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First ALICE Middle LUCINDA Last DAVIS				4. DATE OF DEATH Month July Day 26 Year 19 60			
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1878		9. AGE (In years last birthday) yn. 81		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Henry Greene				14. MOTHER'S MAIDEN NAME Mary Eliza Greene			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Arthur S. Davis Address Gaithersburg, Md. Rt. 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure. 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 19 60 , to July 16 , 19 60 , that I last saw the deceased alive on July 16 , 19 60 , and that death occurred at 5:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 N. Frederick Ave Gaithersburg, Md. DATE SIGNED ACTUAL SIGNATURE Luciano I. Leal M.D. 105 N. Frederick Ave PHYSICIAN'S NAME (Type) Luciano I. Leal Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		7/29/60		John Wesley.		Rooky Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden				ADDRESS Rookyville, Md.		24a. REC'D BY REGISTRAR DATE AUG 2 '60	
				24b. REGISTRAR'S SIGNATURE Charles E. Frank			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8170 CERTIFICATE OF DEATH 08126

1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE VA. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington				c. LENGTH OF STAY IN 1b 6 weeks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kensington Gardens SAN				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARLINGTON 3			
f. STREET ADDRESS 3012 Columbia Pike				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Bessie Middle Poling Last Davis				4. DATE OF DEATH Month 7 Day 16 Year 1960			
5 SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 10, 1876	
9 AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR Months 1 Days 16 Hours 19 Min.		IF UNDER 24 HRS. Months 1 Days 16 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES WM. Poling				14. MOTHER'S MAIDEN NAME MARY JANE Houser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Constrictive Heart FAILURE 4257-9 DUE TO (b) Coronary Arteriosclerosis Heart Failure Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. Senility DUE TO (c) Senility PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from Jan 1, 1960 to 7/16/60 19____, that (I) (we) last saw the deceased alive on 7/15/60 19____, and that death occurred at 12:30 PM M, from the causes and on the date stated above							
22a. SIGNATURE SAM ALLEN, M.D. Kensington, Maryland				22b. DATE SIGNED 7/16/60			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF July 19, 1960		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Ives Funeral Home, Inc. Def. J. C. Gray				ADDRESS Arlington, Virginia		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Houser							



8135

CERTIFICATE OF DEATH

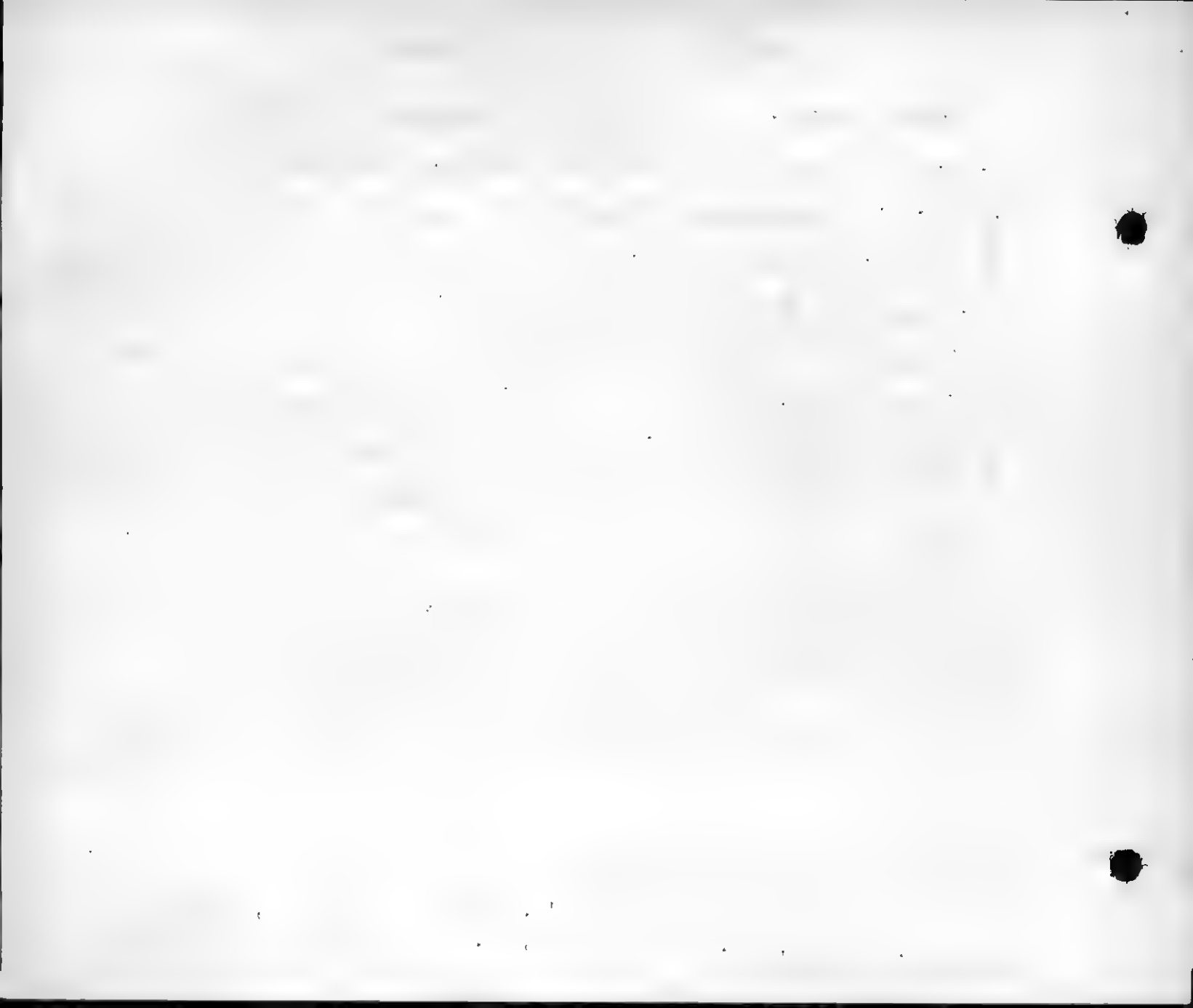
08127

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 4 1/2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanatorium + Hospital				d. STREET ADDRESS 8512 Manchester Rd			
3. NAME OF DECEASED (Type or print) WALTER STERN DAVIS				4. DATE OF DEATH Month 7 Day 1 Year 1960			
5 SEX M	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 5-30-97		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE MANAGER Fed. Com. Comm.				10b. KIND OF BUSINESS OR INDUSTRY D.C.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME Edward F. Davis				14. MOTHER'S MAIDEN NAME Minnie Pope			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO --			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Hypertensive Heart Disease DUE TO (c) years				INTERVAL BETWEEN ONSET AND DEATH Hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct 1953 to June 30, 1960 , that I last saw the deceased alive on June 30, 1960 , and that death occurred at 2:45 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Isidore Shulman				ADDRESS (Street, city or town, state) 915-19th St. N.W.			
PHYSICIAN'S NAME (Type) ISIDORE SHULMAN				DATE SIGNED Wash. D.C.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/60		22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT'L. CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. BUMPHREY, INC. Raymond R. Ziska				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUL 6 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 5

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8136

CERTIFICATE OF DEATH

Reg. Dist. No.

08128

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>18403 Roanoke Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Jack</u> First <u>Zavar Demirdjian</u> Middle <u>Lost</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1960</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 24-1914</u> 9. AGE (In years lost birthday) <u>46</u> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cock</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island</u> 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Aarhon Demirdjian</u> 14. MOTHER'S MAIDEN NAME <u>Mary Pakradounian</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>Tuberculosis - (pulmonary) acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Admission - Extreme Periodic</u> (c) <u>Complications</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5-16-</u> , <u>1960</u> , to <u>7-11-</u> , <u>1960</u> , that I last saw the deceased alive on <u>7-11-</u> , <u>1960</u> , and that death occurred at <u>10:00 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>18403 Roanoke Ave, Tak. Park, Md</u> DATE SIGNED <u>7/11/60</u>							
ACTUAL SIGNATURE <u>Robert H. Hare</u>		PHYSICIAN'S NAME (Type) <u>Robert H. Hare</u>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-16-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash Natl Cemetery</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co</u>		ADDRESS <u>1400 Chapin St</u>		24a. RECD BY REGISTRAR <u>Jul 19 1960</u>			
24b. REGISTRAR'S SIGNATURE <u>Julius S. Hare</u>		24c. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, by the funeral director, and completely filled out by the attending physician and completely filled out by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

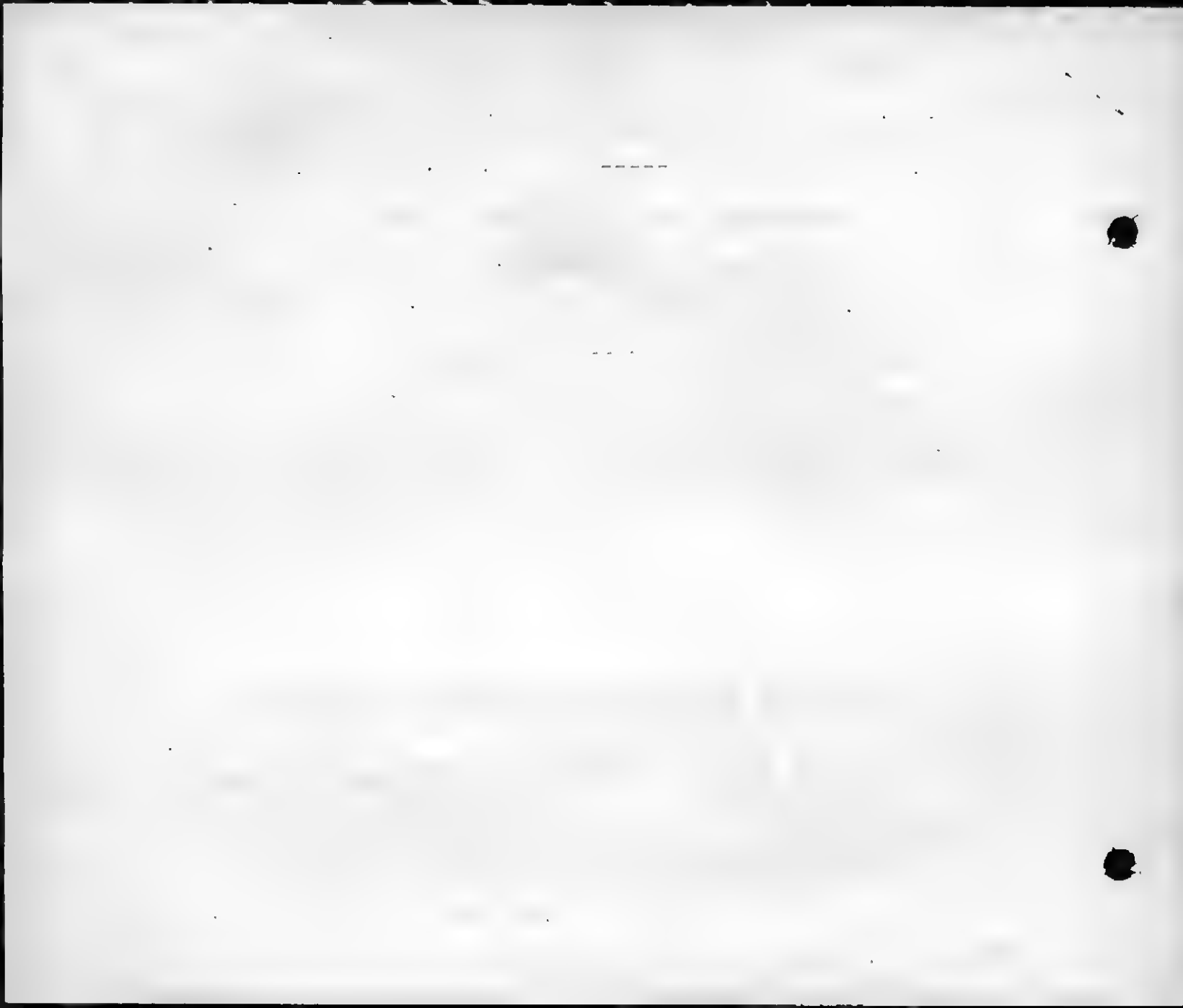
VR AIS (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08129

8211

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wheaton Nursing Home</u>				d. STREET ADDRESS <u>7220 Barnett Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>BESSIE AMANDA DIAMOND</u>				4. DATE OF DEATH <u>JULY 5, 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 18, 1884</u>	
9. AGE (last yr. day) <u>75</u> yrs.		10. IF UNDER 1 YEAR <u>8</u> Months <u>17</u> Days		11. IF UNDER 24 HRS. <u>19</u> Hours <u>17</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>			
11. BIRTHPLACE (State or foreign country) <u>USA. Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas Kiriak</u>				14. MOTHER'S MAIDEN NAME <u>MARY A. Kneeder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Nurse Betty J. Procono</u>				Address <u>-----</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>435.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-----</u> DUE TO (c) <u>-----</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6-6-1960</u> to <u>7-5-1960</u> that (I) (we) last saw the deceased alive on <u>7-4-1960</u> and that death occurred <u>3:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles House</u>				22b. DATE SIGNED <u>7-5-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles House</u>				22d. ADDRESS <u>7701 Carroll Ave. N.T. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/6/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Saviour Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>York County, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				25a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				DATE <u>JUL 7 '60</u>			

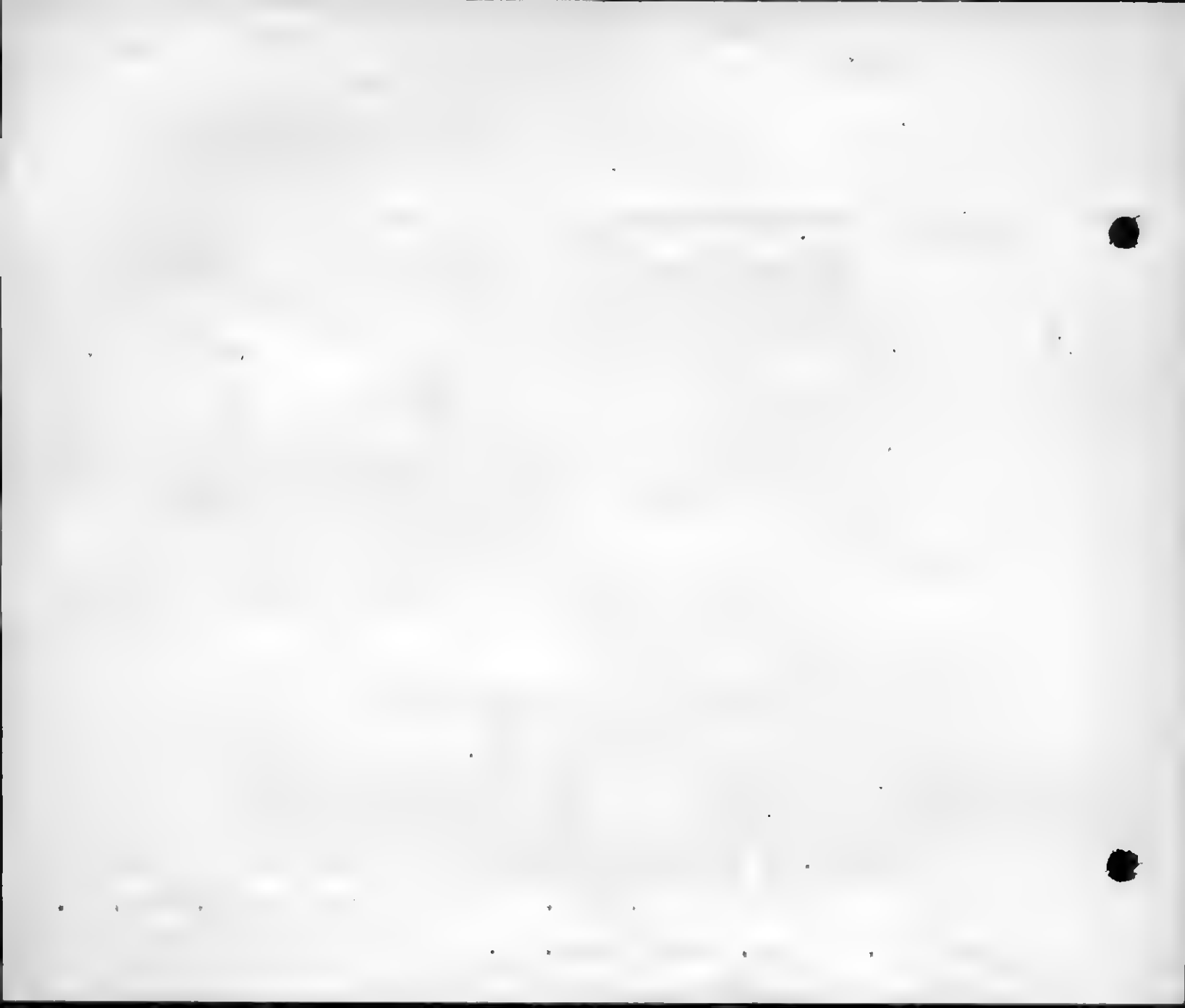


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8212
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08130

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 6 HRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS FULTON	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HERBERT CARVEL DIAMOND		4. DATE OF DEATH Month Day Year JULY 26 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/9/12
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HERBERT LAWRENCE DIAMOND		14. MOTHER'S MAIDEN NAME MARIE JONES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 195-0	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT ADRENAL WITH METASTASES TO LIVER AND LUNGS DUE TO (b) TO LIVER AND LUNGS DUE TO (c) TO LIVER AND LUNGS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BILATERAL LOBAR PNEUMONIA 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from SEPT. 10 1959 to JULY 26 19 60 that (I) (we) last saw the deceased alive on JULY 25 19 60 , and that death occurred at 12:50A M, from the causes and on the date stated above.			
22a. SIGNATURE Charles S. Whitaker, M.D. M.D.		22b. DATE SIGNED 7/26/60	
22c. PHYSICIAN'S NAME (Type) CHARLES S. WHITAKER, M. D.		22d. ADDRESS CLARKSVILLE, MARYLAND	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-28-60	
23c. NAME OF CEMETERY OR CREMATORY St. Rose.		23d. LOCAT ON (City, town, or county) (State) Gaithersburg. Rural. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg. Md.		25a. REC'D BY REGISTRAR JUL 28 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Thoms			



8213

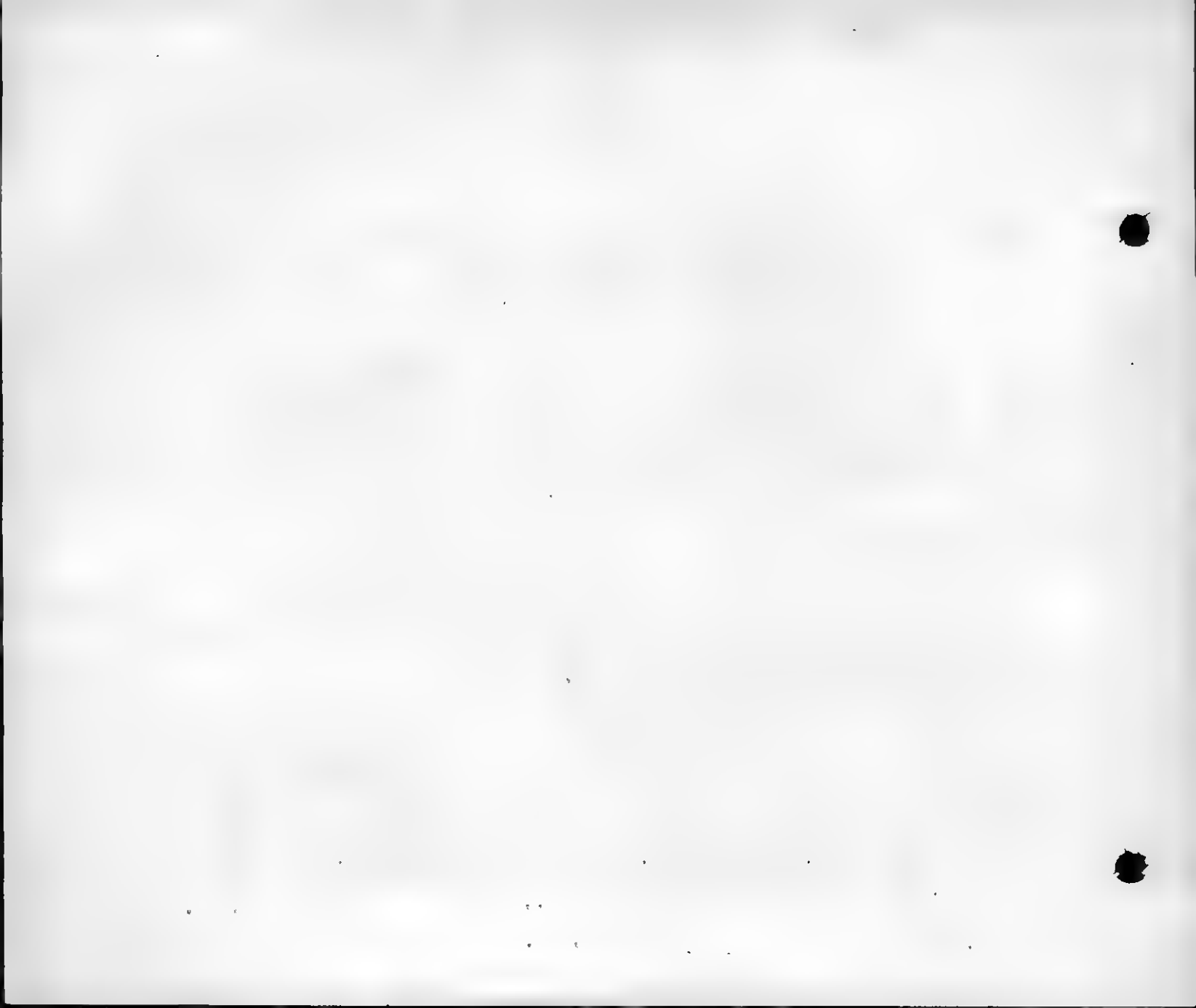
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

08151

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 4 DAYS		X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. STREET ADDRESS ROUTE #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BRYON Middle DEAN Last DOBSON				4. DATE OF DEATH Month JULY Day 22 Year 1960			
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-60		9. AGE (In years last birthday) 4 DAYS	IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 4 Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES EDWARD DOBSON				14. MOTHER'S/MAIDEN NAME JEAN ELOISE MURRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO spontaneous Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH few hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE <i>W. A. Linthicum</i>				22b. DATE SIGNED 7/23/60		22c. PHYSICIAN'S NAME (Type) W. A. LINTHICUM, M. D.	
22d. ADDRESS ROCKVILLE, MARYLAND				22e. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (State)		23b. DATE THEREOF 7/25/60		23c. NAME OF CEMETERY OR CREMATORY Emory Grove.,		23d. LOCATION (City, town, or county) (State) Emory Grove, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Robert L. Sund...</i>				25a. REC'D BY REGISTRAR DATE JUL 21 '60		25b. REGISTRAR'S SIGNATURE <i>Robert L. Sund...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

2273213XV3



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M-7759

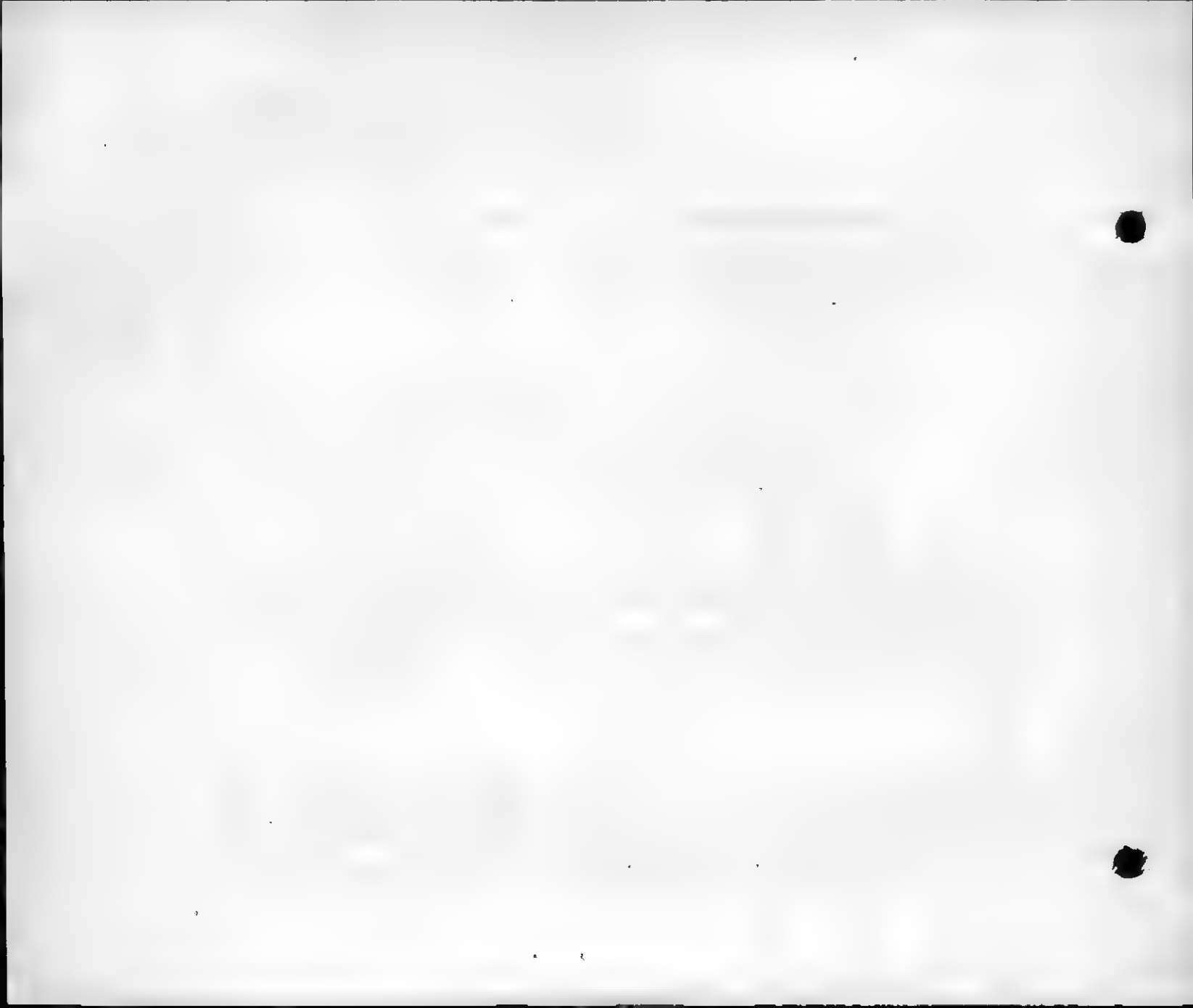
8214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08132

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BYRON Middle EUGENE Last DOBSON		4. DATE OF DEATH Month JULY Day 23 Year 1960	
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-60
9. AGE (In years last birthday) 4 DAYS yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JAMES EDWARD DOBSON		14. MOTHER'S MAIDEN NAME JEAN ELOISE MURRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH few hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M., from the causes and on the date stated above			
22a. SIGNATURE W. A. Linthicum		22b. DATE SIGNED 7/23/60	
22c. PHYSICIAN'S NAME (Type) W. A. LINTHICUM, M. D.		22d. ADDRESS ROCKVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/60	
23c. NAME OF CEMETERY OR CREMATORY Emory Grove.,		23d. LOCATION (City, town, or county) (State) Emory Grove, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surdick		25a. REC'D BY REGISTRAR DATE JUL 27 '60	
ADDRESS Rockville, Md.		25b. REGISTRAR'S SIGNATURE William S. Kline	

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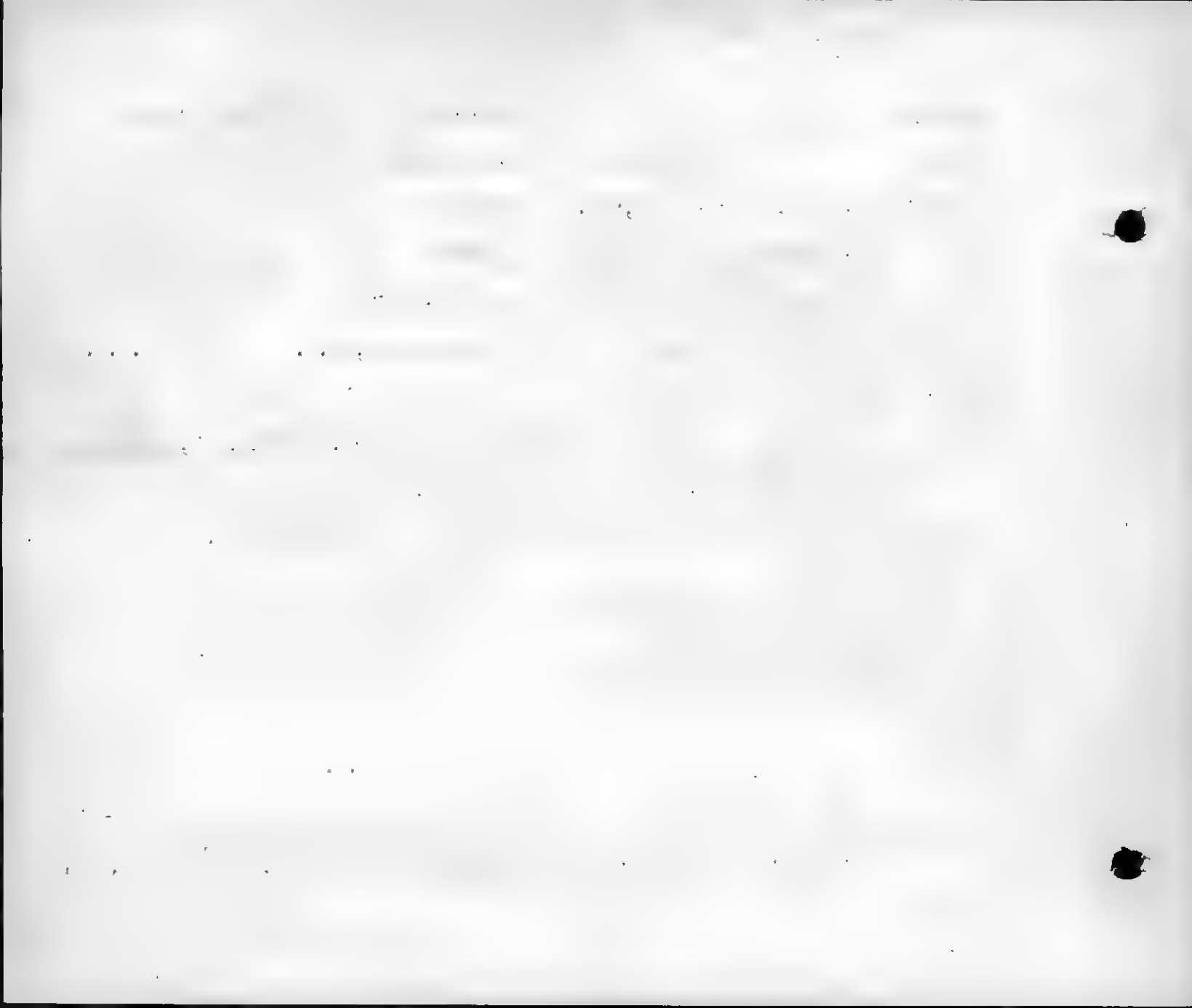


8215

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

08133

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park			
c. LENGTH OF STAY IN 1b 81 days				d. STREET ADDRESS 1675 - 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Katherine Middle Louise Last Donald				4. DATE OF DEATH Month July Day 10 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1953	
9. AGE (In years last birthday) 7 yrs		IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.		IF UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert Donald				14. MOTHER'S MAIDEN NAME Elizabeth Goldsworthy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral and Subdural Hemorrhage 20000 DUE TO (b) Cerebral Metastases of Reticulum Cell Sarcoma. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) 5 days DUE TO (c) 5 Months PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal Ileitis 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20 19 60 to July 10 19 60 that (I) (we) last saw the deceased alive on July 10 19 60 and that death occurred at 11:15 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Jerome B. Block M.D.				22b. DATE SIGNED 7-11-60			
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial July 14, 1960		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Pr. Georges Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co ADDRESS Awardale, Md.				25a. REC'D BY REGISTRAR DATE JUL 15 '60		25b. REGISTRAR'S SIGNATURE W. A. S. Kline	



1
8158
MONTGOMERY
MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08154

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVY CHASE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "HAYES"-MANOR ROAD		d. STREET ADDRESS "HAYES"-MANOR ROAD	
3. NAME OF DECEASED (Type or print) GEORGE THOMAS DUNLOP		4. DATE OF DEATH Month JULY Day 4th Year 1960	
5 SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/25/1870
9. AGE (In years and birthday) 89 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY	
10b. KIND OF BUSINESS OR INDUSTRY TRANSIT		11. BIRTHPLACE (State or foreign country) FREDERICK Co., MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE THOMAS DUNLOP	
14. MOTHER'S MAIDEN NAME EMILY REDIN KIRK		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. —		17. INFORMANT Address A.McCOOK DUNLOP (same as above)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL ARTERIOSCLEROSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 ± yrs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from approx. 19:50 to JULY 4, 1960 that (I) (we) last saw the deceased alive on JULY 4, 1960 , and that death occurred at 11:55 PM , from the causes and on the date stated above.			
22a. SIGNATURE H D Ecker		22b. DATE SIGNED 7/5/60	
22c. PHYSICIAN'S NAME (Type) Henry D. Ecker, M.D.		22d. ADDRESS 917-20th St. N.W., Washington 6, D.C.	
23a. BURIAL CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7-7-1960	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town, or county) (State) Suitland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Gaudin, Jr.		25a. REC'D BY REGISTRAR DATE JUL 7 '60	
ADDRESS 1756-Pa. Ave. N.W., Washington 6, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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[Faint handwritten notes at the bottom of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pay the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

8137

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08135

Phone call, see item 21, et

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u>				c. LENGTH OF STAY IN 1b <u>18 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington D.C. Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Edward Cunningham</u>				4. DATE OF DEATH Month Day Year <u>7 25, 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-24-85</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cameo Furniture Co.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>American</u>				13. FATHER'S NAME <u>George Cunningham</u>			
14. MOTHER'S MAIDEN NAME <u>Blanche Mattingly</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>517-18-9746</u>				17. INFORMANT <u>Hosp Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Diabetes mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>17 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>July 8, 1960</u> to <u>July 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 24, 1960</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above			
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>				22b. DATE SIGNED <u>7-25-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>217 University Blvd E. Sd. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wagner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				25c. DATE <u>JUL 29 '60</u>			



8216 See: Birth Cert. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

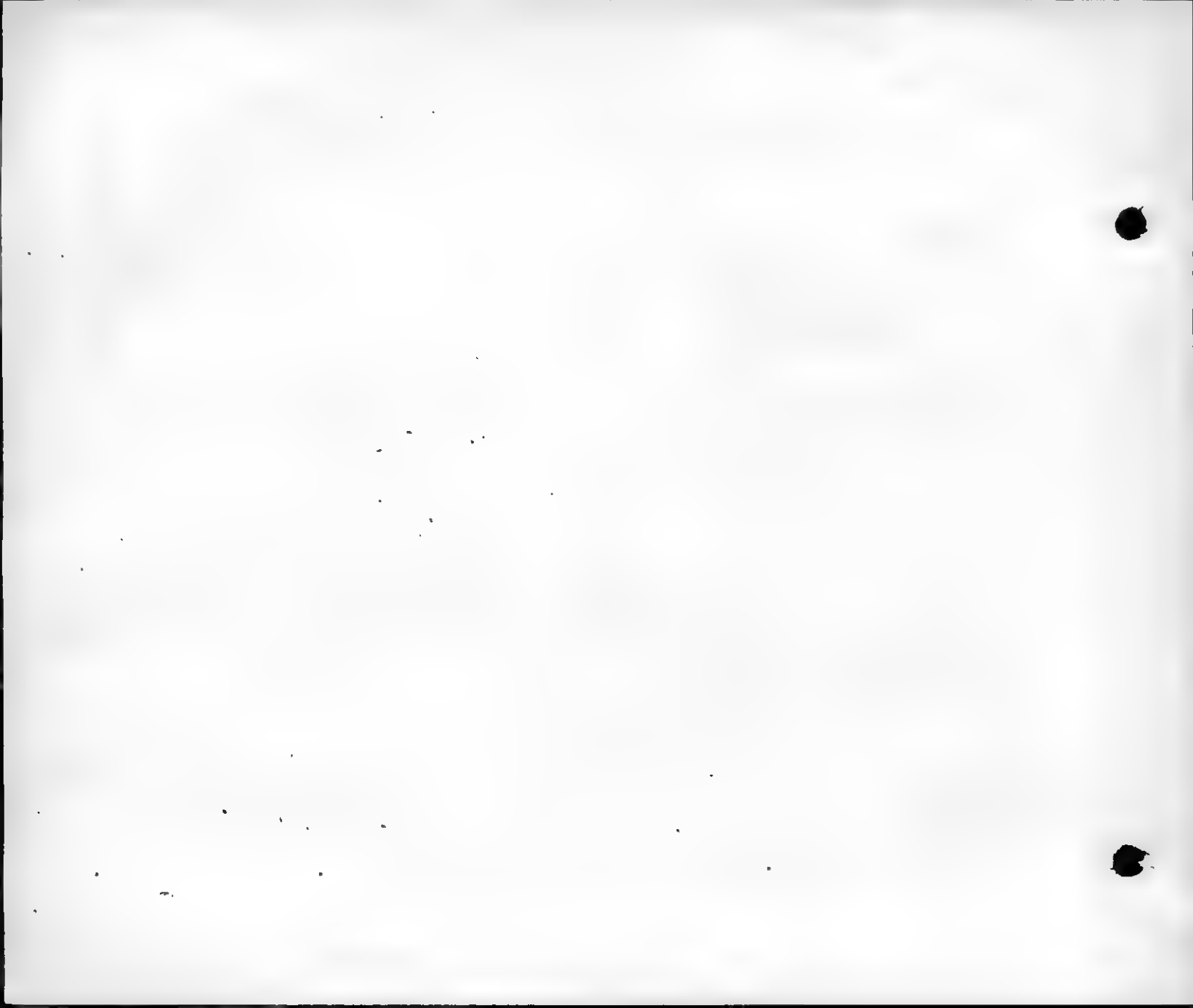
08136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 mo. 30 min</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. STREET ADDRESS <u>P.O. Box 42</u>	
3. NAME OF DECEASED (Type or print) First <u>Betty</u> Middle <u>Gail H</u> Last <u>Fearley</u>		4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8 1960</u>
9. AGE (In years, last birthday) <u>3 yrs</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Paul L. Fearley</u>		14. MOTHER'S MARDEN NAME <u>Bethesda, Nancy Leona</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>father above</u>	
17. INFORMANT <u>father above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis, Pulmonary</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c) <u>Prematurity</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>3 hrs</u> <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>130 AM 7-8-1966</u> to <u>445 AM 7-8-1966</u> that I last saw the deceased alive on <u>7-8-60</u> and that death occurred at <u>445 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville, Md</u> DATE SIGNED <u>7-8-60</u>	
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>		<u>809 Viers Mill Rd. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7-9-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital</u>		24a. REC'D BY REGISTRAR <u>DATE 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8217 See: Birth Cert. CERTIFICATE OF DEATH

Reg. Dist. No. **0815**

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>8 hrs. 35 min</u> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Suburban</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>German town</u> d. STREET ADDRESS <u>P.O. Box 42</u>			
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Baker</u> 4. DATE OF DEATH Month <u>July</u> Day <u>8</u> Year <u>1960</u>			5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 8, 1960</u> 9. AGE (In years last birthday) <u>8 hrs. 35 yrs.</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>U.S. Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				
13. FATHER'S NAME <u>Paul L. Baker</u> 14. MOTHER'S MAIDEN NAME <u>Burgess, Nancy Leona</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> INFORMANT <u>father - above</u> Address <u>None</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis Pulmonary</u> DUE TO <u>Immaturity</u> (b) <u>Prematurity</u> DUE TO <u>None</u> (c) <u>None</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year <u>July 8, 1960</u> Hour o. m. <u>7:35</u> p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>		21. I certify that I attended the deceased from <u>1:30 AM 7-8, 1960</u> to <u>9 AM 7-8, 1960</u> that I last saw the deceased alive on <u>7-8, 1960</u> and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville Md.</u> DATE SIGNED <u>7-8-60</u> ACTUAL SIGNATURE <u>Francis J. Troendle M.D.</u> PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u> <u>809 Viers Mill Rd. Rockville, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u> 22b. DATE THEREOF <u>7-9-60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u> 22d. LOCATION (City, town, or county) <u>8600 C. C. Brown Rd. Bethesda, Maryland</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 C. C. Brown Rd. Bethesda, Maryland</u> ADDRESS <u>8600 C. C. Brown Rd. Bethesda, Maryland</u> 24a. REC'D BY REGISTRAR <u>Jul 12 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knapp</u>					

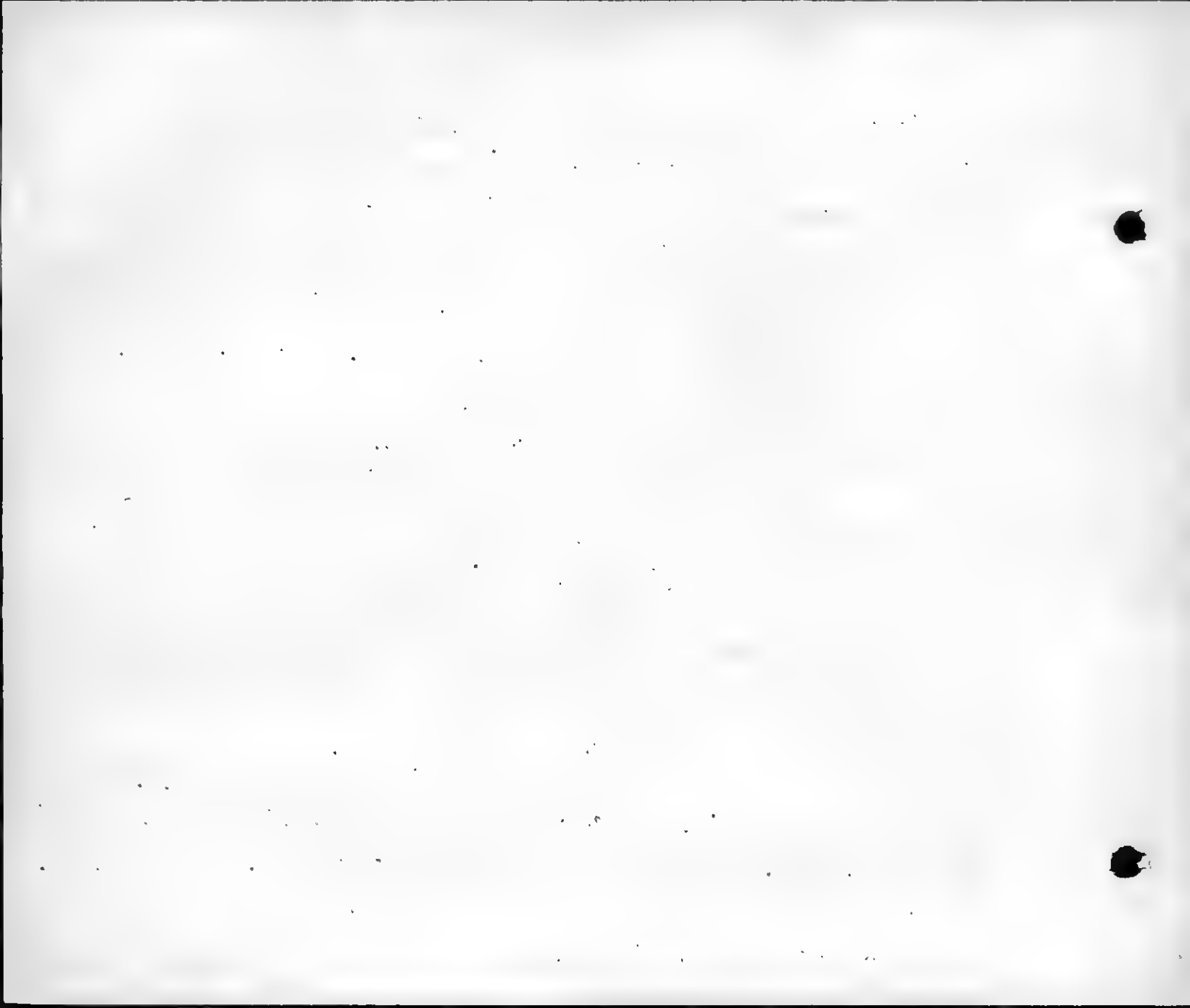
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

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Nov 2 74 193 XV 0 Bethesda, Maryland



8218

CERTIFICATE OF DEATH

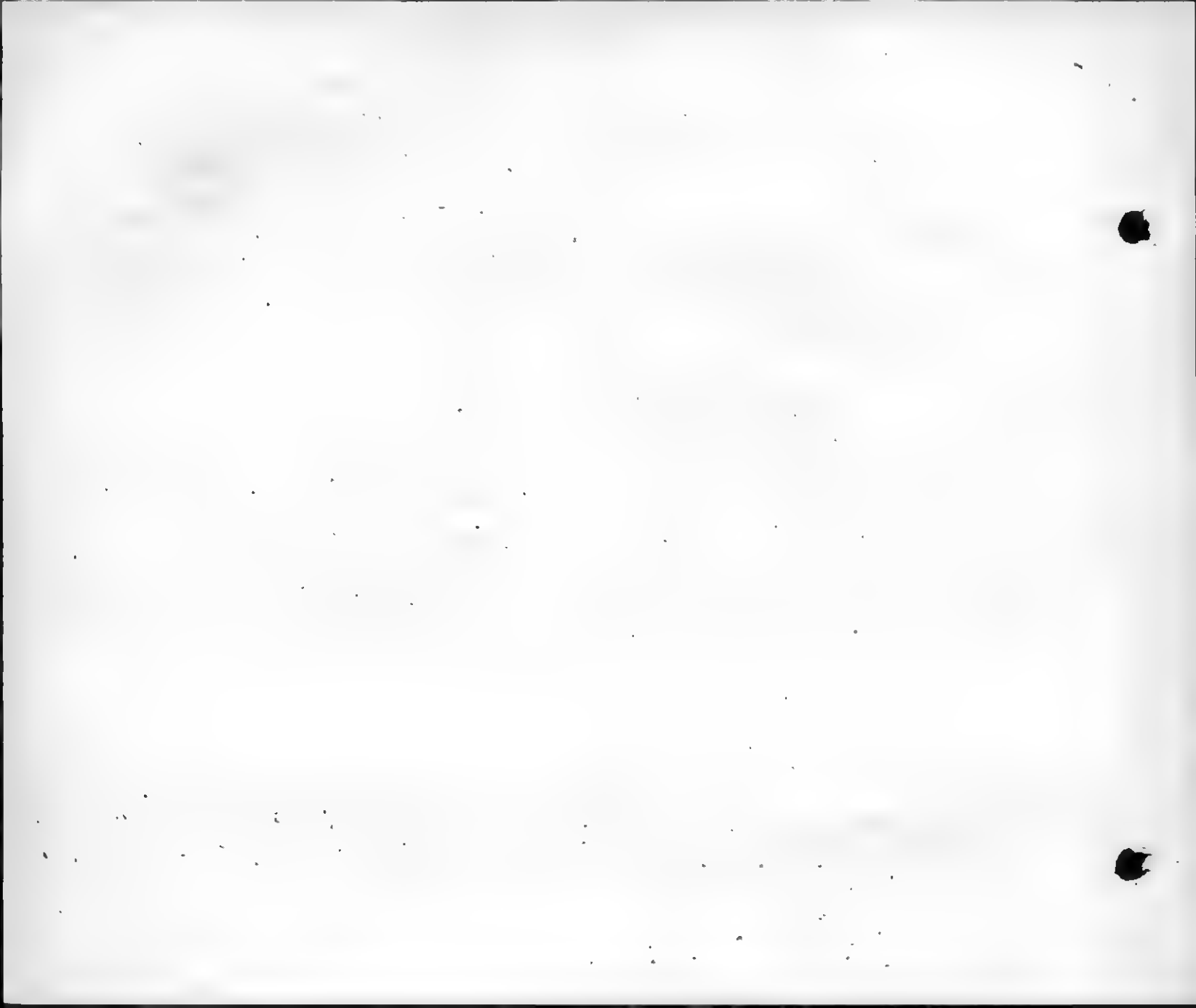
08138

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1 day, 7 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>5201-White Flint Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Eckles</u> Last <u>Eckles</u>		4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1960</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Stanley Eckles</u>		14. MOTHER'S MAIDEN NAME <u>Ruth Rowe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mother's chart -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.4</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac Depletion</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypoglycemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-</u> 19 <u>60</u> to <u>7-2-</u> 19 <u>60</u> , that I last saw the deceased alive on <u>5 PM on 7-2, 1960</u> , and that death occurred at <u>7⁵⁵ P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u> DATE SIGNED <u>7/2/60</u>			
ACTUAL SIGNATURE <u>Francis J. Troendle</u> M.D.		PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/6/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>Jul 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2074 2-83 X V 6



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be signed by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

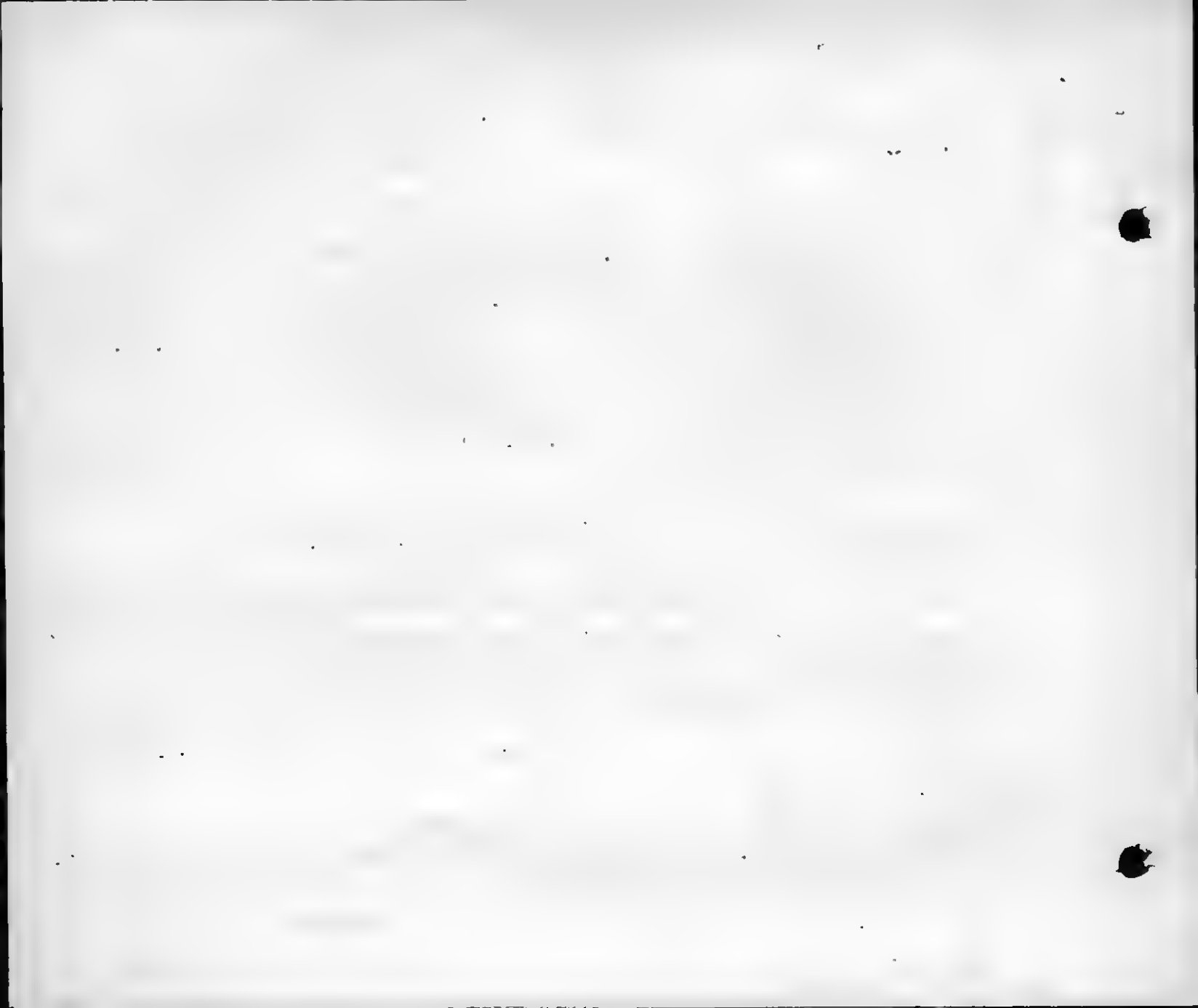
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8219

08139

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 66 Bethesda			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital				e. STREET ADDRESS 9412 Rosehill Drive			
3. NAME OF DECEASED (Type or print) First RICHARD Middle B. Last EDELEN				4. DATE OF DEATH Month July Day 27 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 5, 1872	
9. AGE (In years last birthday) 87 yrs		10. UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		11. UNDER 24 HRS Months 1 Days 1 Hours 1 Min.		12. UNDER 24 HRS Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Retired			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Philip Edelen				14. MOTHER'S MAIDEN NAME Fannie Steed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Son R. Edwin Edelen				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) uremia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) generalized arteriosclerosis DUE TO (c) grave							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerotic heart disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 1956 to July 27, 1960 that (I) (we) last saw the deceased alive on July 26, 1960 , and that death occurred at 11 PM , from the causes and on the date stated above.							
22a. SIGNATURE Wilfred R. Ehrmentraut M.D.				22b. DATE SIGNED July 27, 1960			
22c. PHYSICIAN'S NAME (Type) Wilfred R. Ehrmentraut				22d. ADDRESS 3890 Battery Lane, Bethesda, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7/30/60			
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem				23d. LOCATION (City, town, or county) (State) Silver Spring, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25. REGISTRAR'S SIGNATURE Arthur S. Hines			
ADDRESS Bethesda, Maryland				DATE JUL 28 '60			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

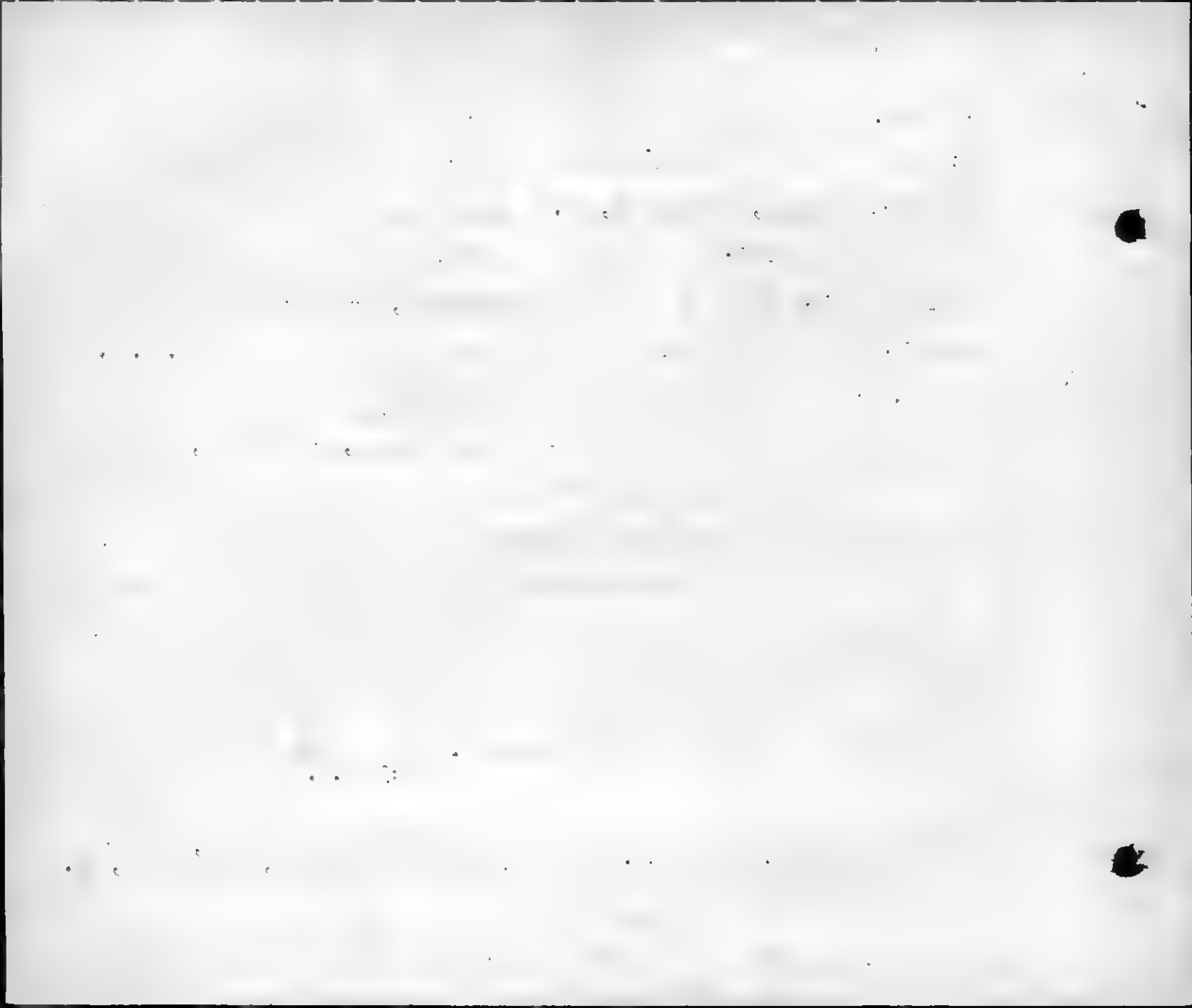
VR A15 (4)
15M 9/59

8220

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08140

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Iowa b. COUNTY Keokuk ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 165 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keola		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS Box 224		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bergie Middle Louava Last Evans				4. DATE OF DEATH Month July Day 8 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 22, 1891	
9. AGE (In years last birthday) 68 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Alvin L. Fry				14. MOTHER'S MAIDEN NAME Myrtee Reed			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Metastases to Heart DUE TO (c) Mycosis Fungoides						INTERVAL BETWEEN ONSET AND DEATH 2 weeks Unknown 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 25, 1960, to July 8, 1960, that (I) (we) last saw the deceased alive on July 8, 1960, and that death occurred at 11:37 P.M. from causes and on the date stated above							
22a. SIGNATURE <i>Jerome B. Block</i> M.D.				22b. DATE SIGNED 7/9/60			
22c. PHYSICIAN'S NAME (Type) JEROME B. BLOCK, M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit		23b. DATE THEREOF 7/10/60		23c. NAME OF CEMETERY OR CREMATORY Keota Cemetery		23d. LOCATION (City, town, or county) (State) Keota, Iowa	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 12 '60	
				25b. REGISTRAR'S SIGNATURE <i>Robert S. Thomas</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
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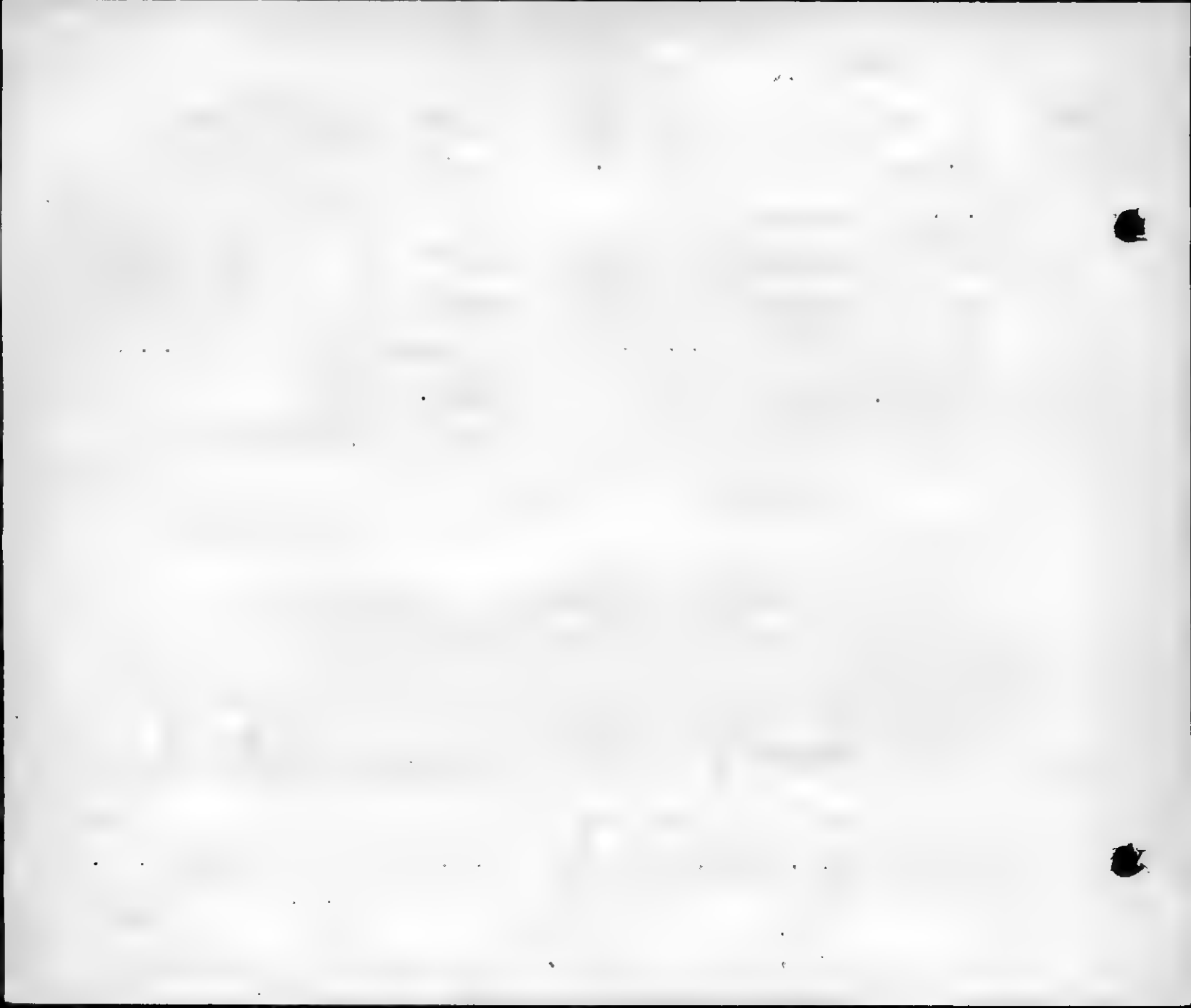
VR A15 (4)
15M 9/59

8221

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0814;

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 9 hrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 617 Blandford Street • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kathleen First Middle Last FERRIS		4. DATE OF DEATH Month Day Year July 16 1960	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-60
9. AGE (In years last birthday) yrs 9		10. IF UNDER 1 YEAR: Months Days Hours Min. 9	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Douglas G. FERRIS		14. MOTHER'S MAIDEN NAME Joyce N. BAKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Douglas Ferris (F), same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Erythroblastosis Fetalis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prematurity and Immaturity			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from July 16 1960 to July 16 1960 , that (I) did did not see the deceased alive on July 16 1960 , and that death occurred at 10:30AM M, from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 7-16-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 20/60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Adams Funeral Home, 4748 Wisconsin Ave., N.W.		25a. REC'D BY REGISTRAR Jul 20 '60	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

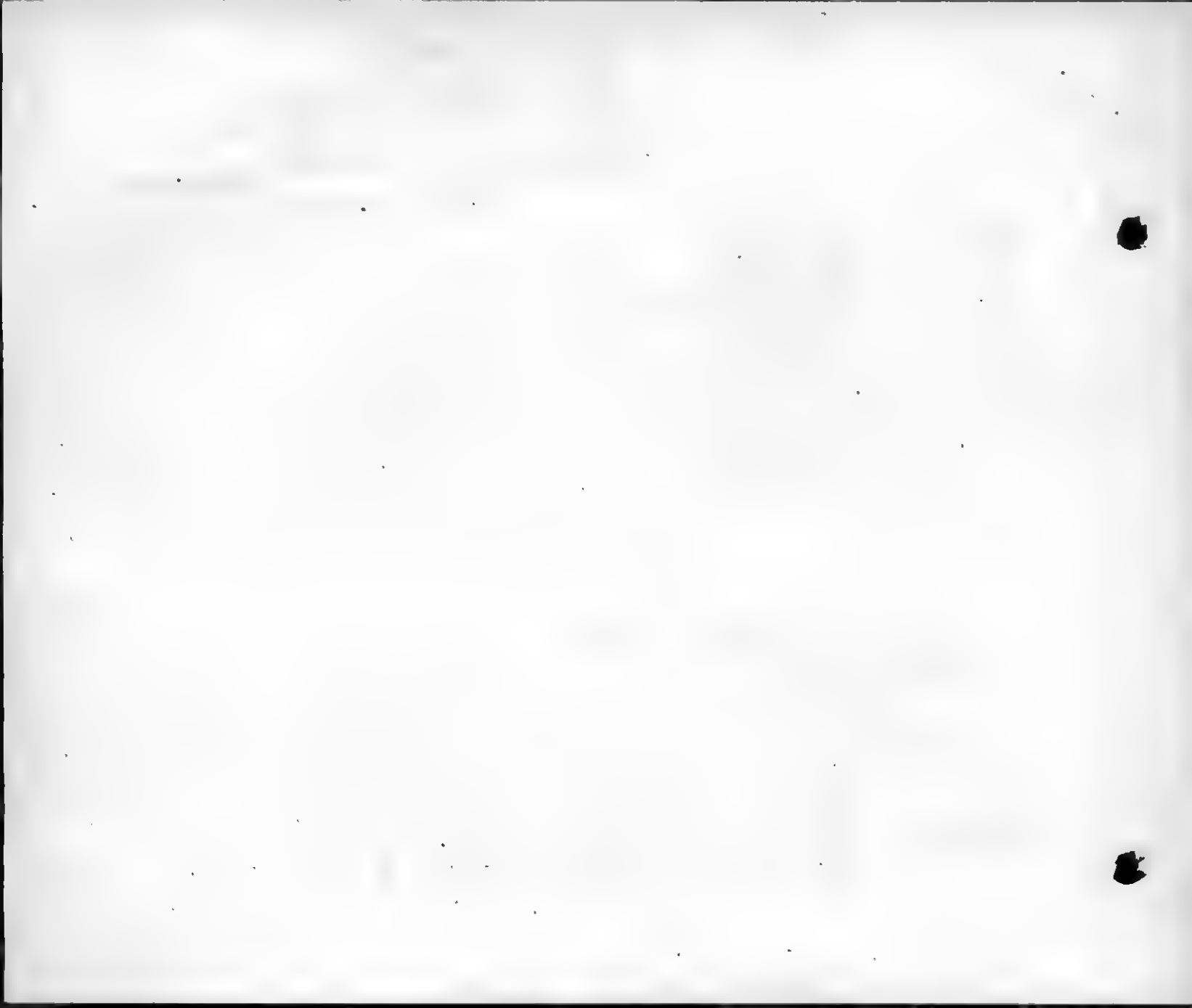
VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8222 Item 7 Film 6268 8-5-60 et
CERTIFICATE OF DEATH

Reg. Dist. No.

08142

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE Maryland COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 90days 10hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
3. NAME OF DECEASED (Type or print) William E. Fields		f. STREET ADDRESS 12408 Ga. Ave.	
4. DATE OF DEATH July 29 1960		g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/73
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Montgomery County		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Rash Fields		14. MOTHER'S MAIDEN NAME Mary Elizabeth Fields	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 578-10-7835	
17. INFORMANT Mrs. Charles Causy		Address 12408 Ga. Ave. S. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: +500 IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Benign Prostatic Hypertrophy		INTERVAL BETWEEN ONSET AND DEATH July 15, 1960 ischemic	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10620 Georgia Ave. Silver Spring, Md.	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 19 July , 1960, to 29 July , 1960, that I last saw the deceased alive on 29 July , 1960, and that death occurred at 8:10 A. M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Michael Dobridge M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 10620 Georgia Ave. Silver Spring, Md.	
PHYSICIAN'S NAME (Type) Michael Dobridge		10620 Georgia Ave. Silver Spring, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/1/60	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
22d. LOCATION (City, town, or county) (State) Suitland, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey	
ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 3 '60	
24b. REGISTRAR'S SIGNATURE Carlina S. Hanna			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
BM 2/57

8113

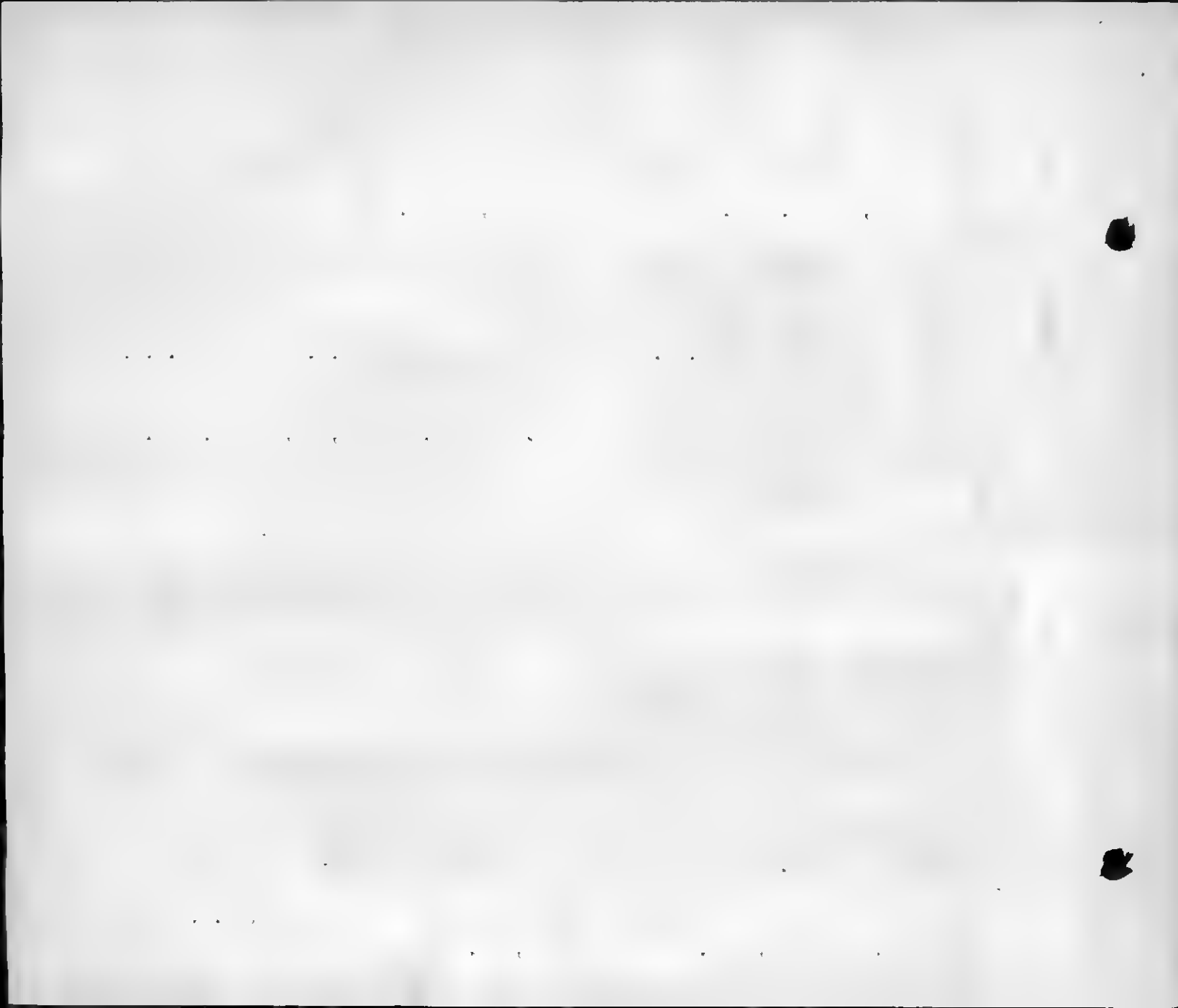
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08143

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
c. LENGTH OF STAY IN 1b since 6/24/44			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13,420 Ga. Ave.		d. STREET ADDRESS 13,420 Ga. Avenue	
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELSA LOHMANN FINNEY		4. DATE OF DEATH Month JULY Day 27 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/11/98
9. AGE (in years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JASPER LOHMANN		14. MOTHER'S MAIDEN NAME CLARA SONNENBERG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mr. Doyal D. Finney, 13,420 Ga. Ave. Silver Spring, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crowning Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardio Vascular Disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hr.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) JOHN G. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 27 July 60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7/30/60	22c. NAME OF CEMETERY OR CREMATORY GLENWOOD CEMETERY	22d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS WYNEK E. PUMPHREY, INC. SILVER SPRING, MD. Raymond E. Ziska		24a. REC'D BY REGISTRAR DATE AUG 1 '60	24b. REGISTRAR'S SIGNATURE C. L. S. H. H. H.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

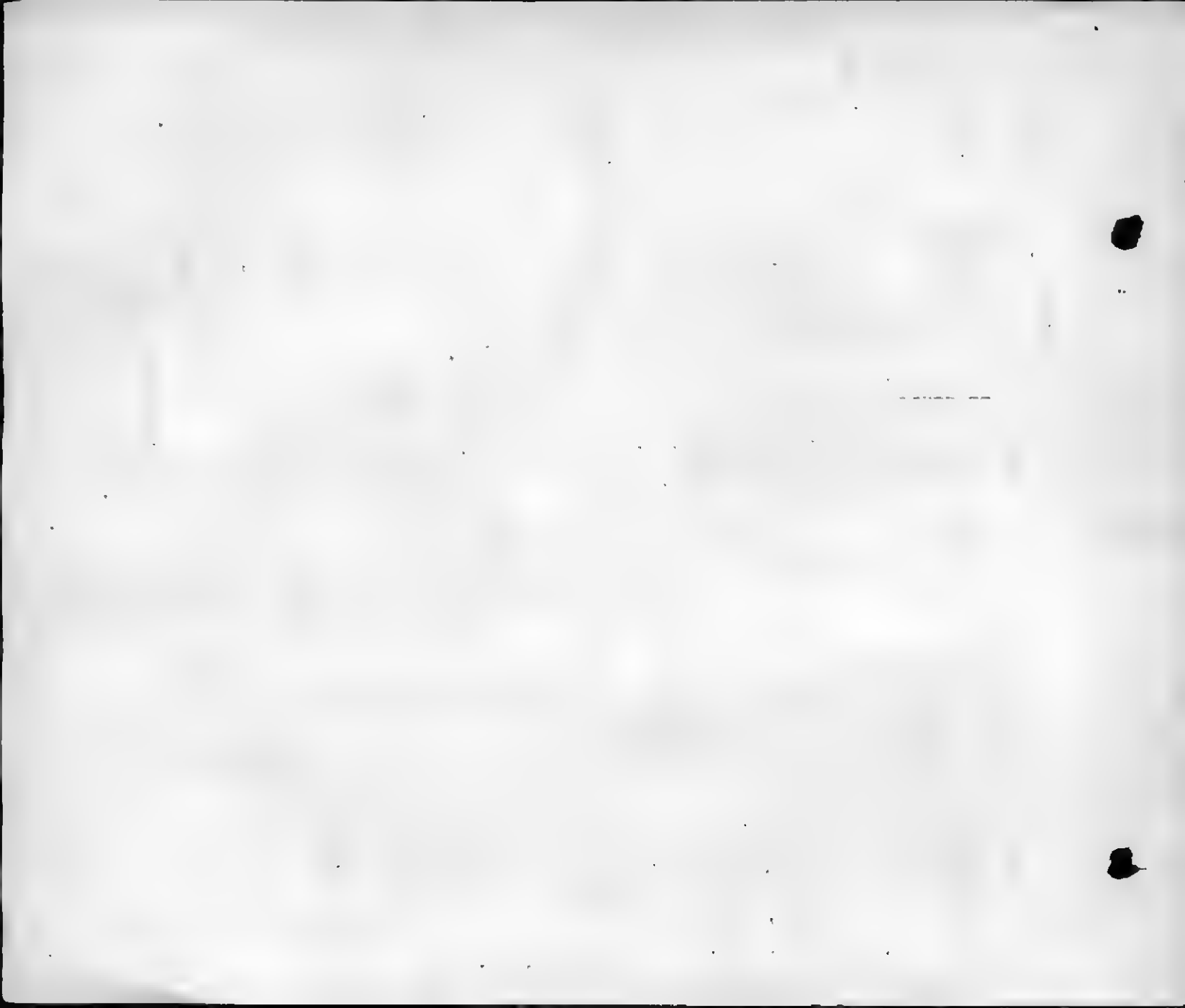
Reg. Dist. No. **0814**

8114

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 5 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13111 Superior St		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 13111 Superior St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Adelia Franklin		4. DATE OF DEATH July 5, 1960 Month July Day 5 Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/4/1919 9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Minn.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leander -Leonander Mattson		14. MOTHER'S MAIDEN NAME Mary Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES [If yes, give war or dates of service] WW # 2		16. SOCIAL SECURITY NO 394-20-0825	
17. INFORMANT David L. Franklin (husband)		Address Item 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Rheumatic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH hrs. months	
PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 7/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF July 8, 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		ADDRESS SILVER SPRING, MD.	
24a. REC'D BY REGISTRAR July 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

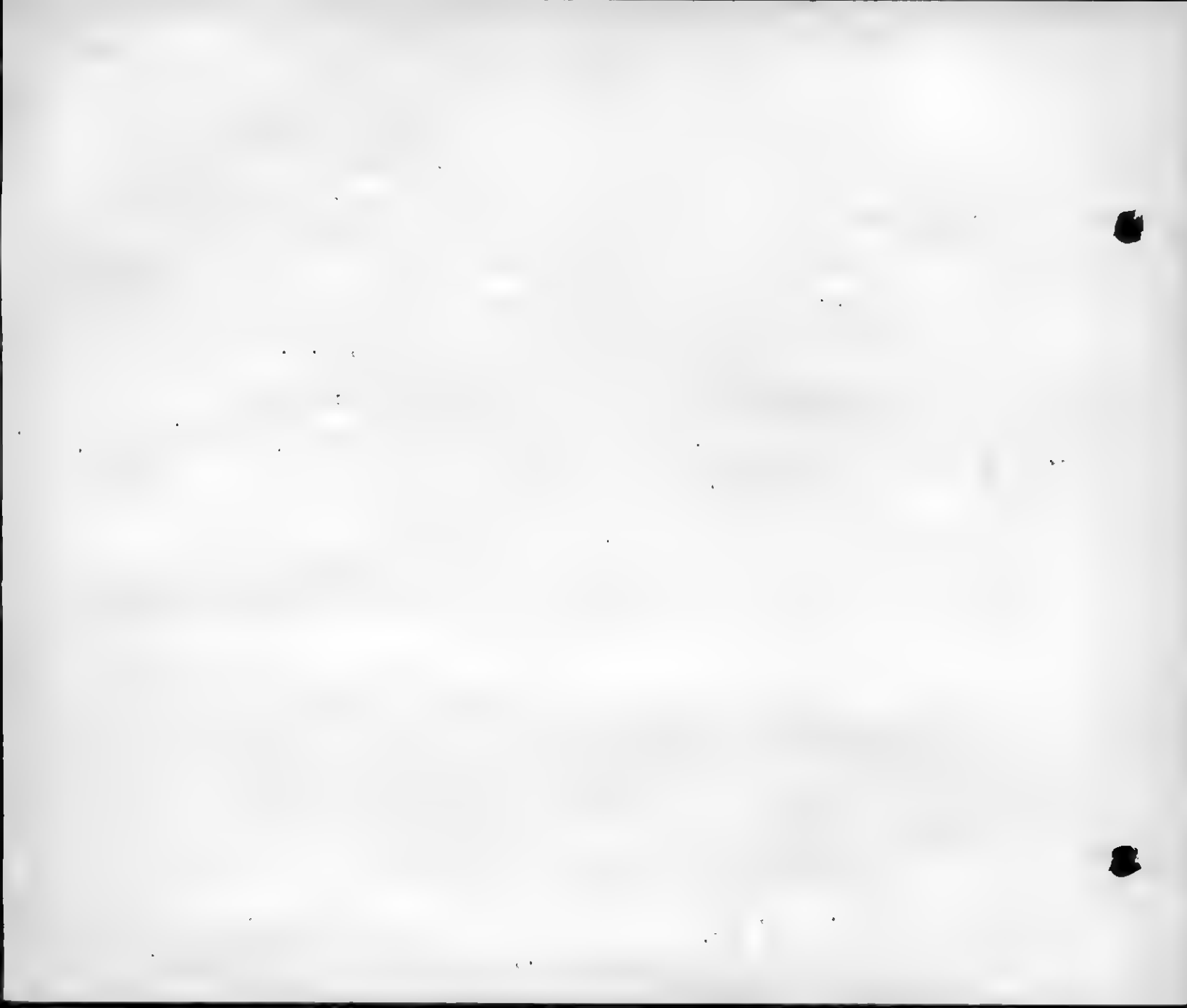
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ISM 9/59

8171

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08145

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>7</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. LENGTH OF STAY IN 1b <u>57</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>1954 Rosemary Hills Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALICE</u> First		Middle <u>MAY</u>		Last <u>FREEMAN</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 24, 1900</u>		9. AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>hotel manager</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Raleigh Brock</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Atkinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-46-8468</u>		17. INFORMANT <u>Halter Truman</u> Address <u>1954 Rosemary Hills Dr. Silver Springs, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast</u> DUE TO (b) <u>Melancholy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Metastatic Carcinoma of breast + pelvic bones</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cervix, Secondary</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs</u> <u>1 1/2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 6, 1955</u> to <u>7/29/60</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>7/21/60</u> 19 <u>60</u> , and that death occurred on <u>7/29/60</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. O'Keefe MD</u> M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>James A. O'Keefe MD</u>				22d. ADDRESS <u>4501-Cornell Ave. Washington DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>August 2, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Jones</u> ADDRESS <u>2847 Wilson Blvd. Arlington, Virginia</u>				25a. REC'D BY REGISTRAR <u>AUG 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

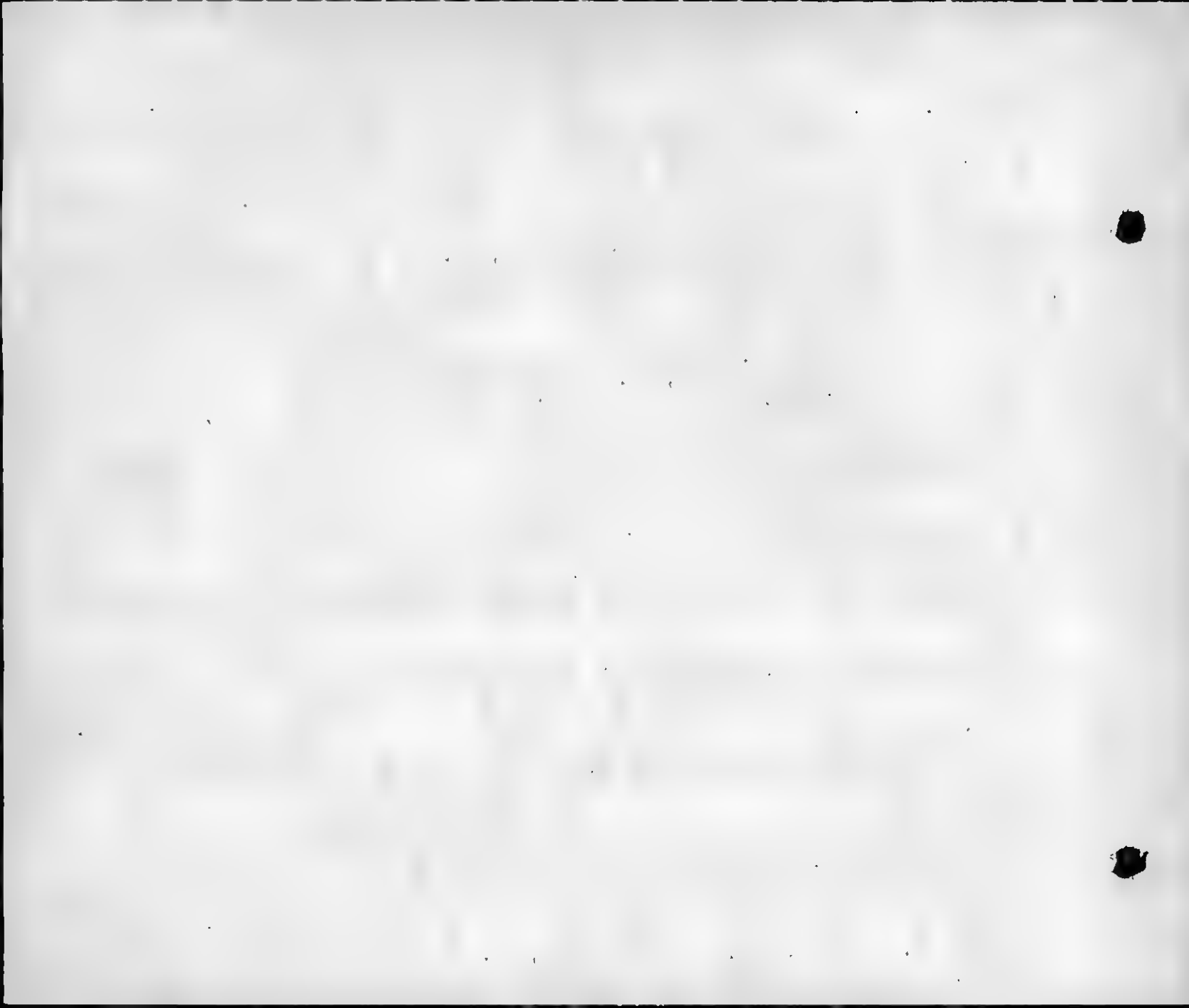
8223

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08146

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban		e. STREET ADDRESS 701 Silver Spring Ave.	
3. NAME OF DECEASED (Type or print) William Francis FURRY, JR.		4. DATE OF DEATH Month July Day 1 Year 1960	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/41
9. AGE (In years last birthday) 19 yrs.		IF UNDER 1 YEAR Months 1 Days 19	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT		10b. KIND OF BUSINESS OR INDUSTRY GAS station attendant	
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANCIS FURRY, SR.		14. MOTHER'S MAIDEN NAME MARY ELSEA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT MR. W. M. FURRY (FATHER)		Address 7324 85TH AVE. HYATTSVILLE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage-lacerations DUE TO (b) Skull fracture DUE TO (c) Automobile accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was passenger in car which failed to make curve & struck pole	
20c. TIME OF INJURY Month, Day, Year 12:40 a.m. 7/1/60 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway		20f. (City or town) (County) (State) Darnestown Montg Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/5/60	
22c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WALTER E. PUMPHREY, INC. Raymond A. Ziska		24a. REC'D BY REGISTRAR DATE JUL 6 '60	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



8224

CERTIFICATE OF DEATH

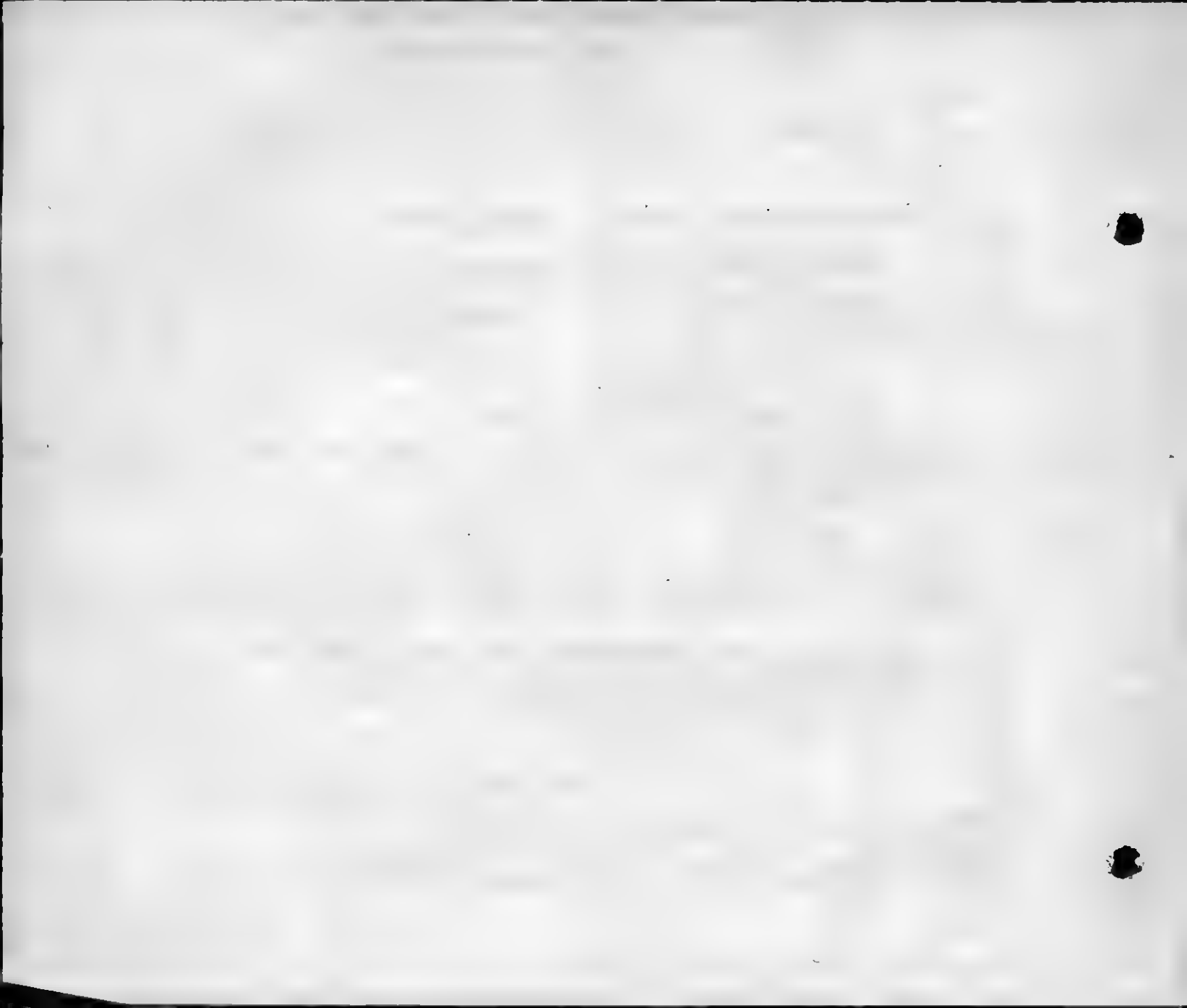
Reg. Dist. No.

08147

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA - RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (BROOKDALE)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5025-Brookdale Road</u>		d. STREET ADDRESS <u>15025-Brookdale Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>-</u> Last <u>Gallagher</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Gallagher</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kelch</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>Lida F. Gallagher</u>		Address <u>5025 Brookdale Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIO SCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>ONE DAY</u> <u>2 YEARS</u> <u>6 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>9:00</u> p.m. <u>7</u> <u>30</u> <u>1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/16</u> , 19 <u>60</u> , to <u>7/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/30</u> , 19 <u>60</u> , and that death occurred at <u>9:00</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas F. O'Connor</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>4861 BATTERY LANE</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR</u>		<u>BETHESDA 14, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 1, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Don. DeVol</u>		ADDRESS <u>2224-Wisconsin-D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 1 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8138

CERTIFICATE OF DEATH

08148

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <i>Maryland</i> c. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8510 Flower Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Donald Blount Gatling</i>		4. DATE OF DEATH <i>July 2, 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>August 18, 1899</i>
9. AGE (In years last birthday) <i>60</i> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Attorney Federal Trade Com.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Federal Govt.</i>	
11. BIRTHPLACE (State or foreign country) <i>Forest City, Arkansas</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Gatling</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give way or date of service) <i>W.W.I.</i>		16. SOCIAL SECURITY NO. <i>Ronald B. Gatling, Jr., 2406 Colston Dr. S.S. Md</i>	
17. INFORMANT <i>Ronald B. Gatling, Jr.</i>		Address <i>2406 Colston Dr. S.S. Md</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> DUE TO <i>Atherosclerotic Heart Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1, 1960</i> to <i>July 2, 1960</i> , that I last saw the deceased alive on <i>July 1, 1960</i> , and that death occurred at <i>7:10 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William H. Bennett</i>		M.D. <i>BENNETT A. RUBIN, M.D.</i>	
PHYSICIAN'S NAME (Type) <i>William H. Bennett</i>		DATE SIGNED <i>7/2/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>July 6, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Hanes</i>		ADDRESS <i>254 Carroll St. N.W. S.E.</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Hanes</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>	
DATE <i>JUL 6 '60</i>			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8225
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b WASHINGTON d. NAME OF HOSPITAL (If not in hospital, give street address) SUBURBAN HOSPITAL		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 4636 TILDEN STREET, N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First THEMY Middle S. Last GEORGI		4. DATE OF DEATH Month JULY Day 29 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH MAY 31, 1891
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MUSIC TEACHER		10b. KIND OF BUSINESS OR INDUSTRY Dardanelles, Asia Minor, Turkey	
11. BIRTHPLACE (State or foreign country) Dardanelles, Asia Minor, Turkey		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SoTinius Georgi		14. MOTHER'S MAIDEN NAME Helen Cyrmos	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT HOSPITAL RECORD		Address BETHESDA, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pelvis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of prostate DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 1 year 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-1 , 19 58 , to July 29 , 19 60 , that I last saw the deceased alive on July 28 , 19 60 , and that death occurred at 4 4 M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Bethesda, B. Rude M.D. 7/29/60 ACTUAL SIGNATURE Gilbert B. Rude 3900 Military Road PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF AUG. 2/60	
22c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		22d. LOCATION (City, town, or county) (State) PRINCE GEO. CO., MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hyung		24a. REC'D BY REGISTRAR Aug 1 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hume		24c. ADDRESS 1300 N St. N.W. Washington D.C.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



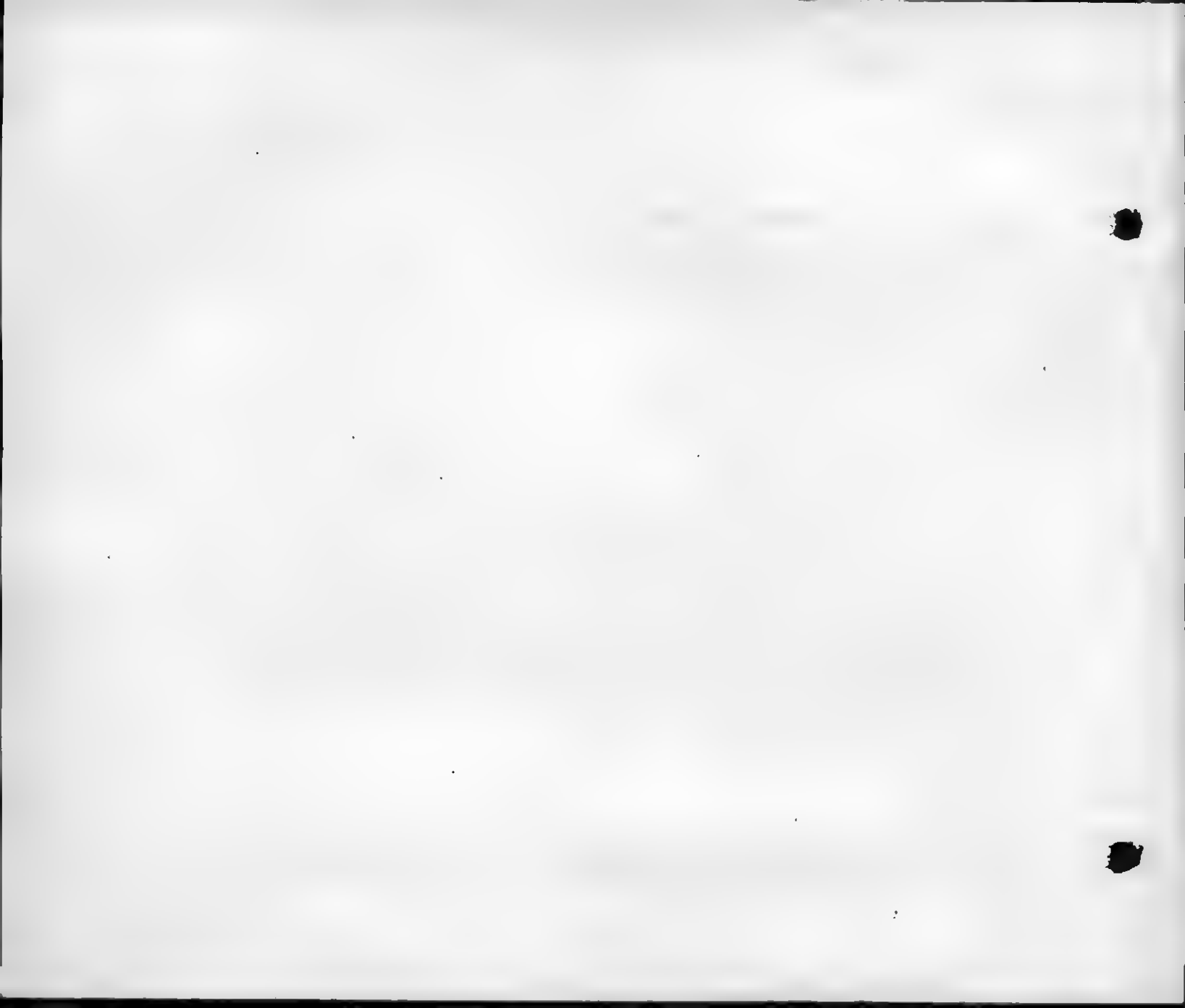
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
8226
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08150

1. PLACE OF DEATH a. COUNTY <i>Maryland</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>DC</i> b. COUNTY <i>✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Olney</i>		c. LENGTH OF STAY IN 1b <i>4 1/2 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brookgrove Foundation</i>		d. STREET ADDRESS <i>6812 Laurel St., N.W.</i>	
3. NAME OF DECEASED (Type or print) <i>Herbert H. Gardner</i>		4. DATE OF DEATH <i>July 1 1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 5, 1881</i>
9. AGE (In years last birthday) <i>79</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Missouri</i>
13. FATHER'S NAME <i>William Abernathy</i>		14. MOTHER'S MAIDEN NAME <i>Olivia Ann Morelock</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Hasp. Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypostatic Pneumonia</i> DUE TO <i>3 da</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Vascular Accident</i> DUE TO <i>3 da</i> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/26/1959</i> to <i>7/1 1960</i> that (I) (we) last saw the deceased alive on <i>7/1 1960</i> and that death occurred at <i>1:45 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard T. Monse</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Dr. Howard T. Monse</i>		22d. ADDRESS <i>7030 Carroll Ave. Tak Pk. Md</i>	
23a. BURIAL, CREMATION, OR REMOVAL (Type or print)		23b. DATE THEREOF <i>7-5-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Lee's Crematorium</i>		23d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Lees</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Wash. D. C.</i>		DATE <i>JUL 6 '60</i>	



8227

CERTIFICATE OF DEATH

08151

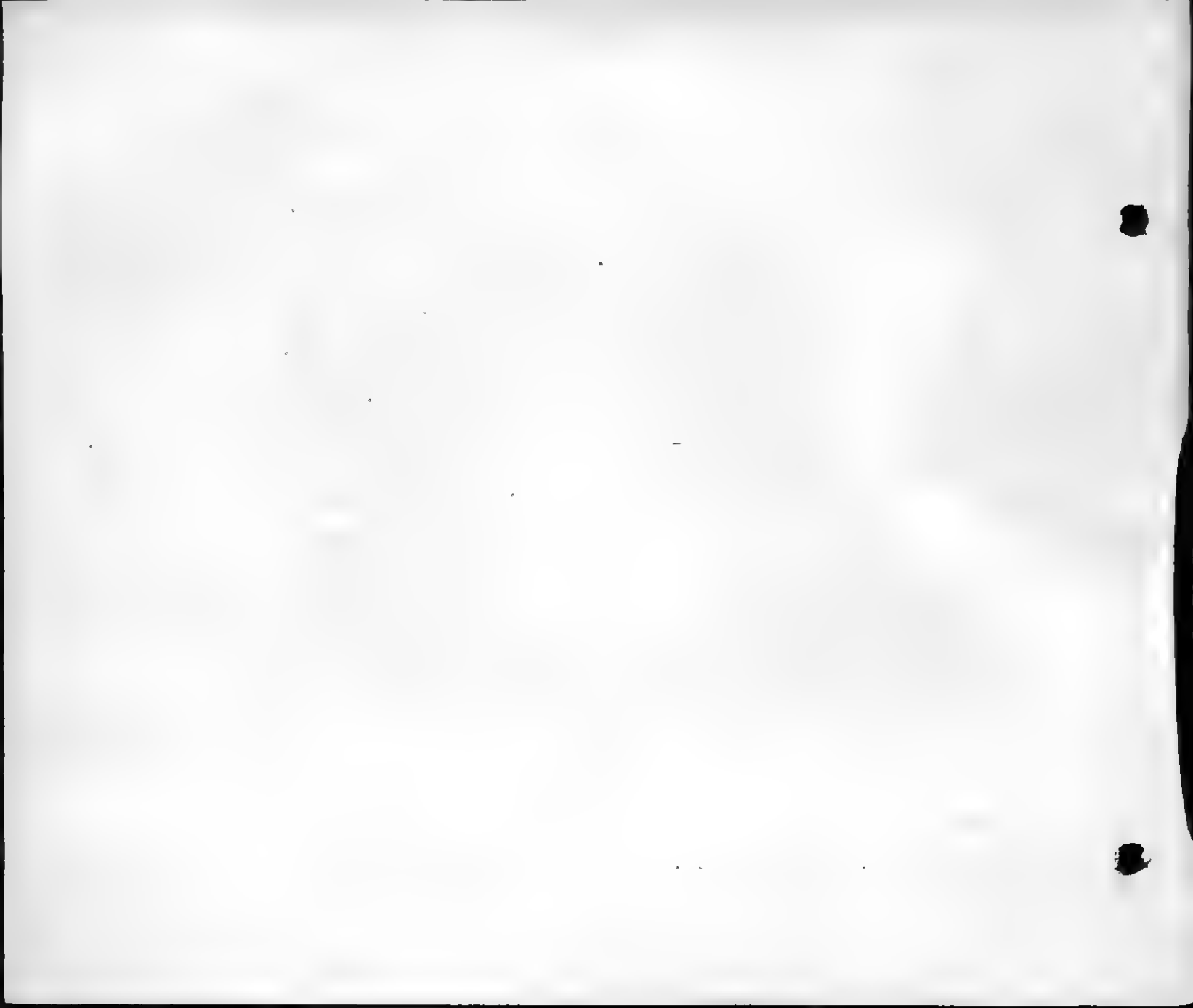
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Montg. Co. Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Iris Middle L. Last Gladhill				4. DATE OF DEATH Month July Day 22 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1909	
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Lewisdale, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James B. Grimes				14. MOTHER'S MAIDEN NAME Della E. Lyddard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO ---			
17. INFORMANT William U. Gladhill, Monrovia, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion, acute DUE TO 420-1 Hypertensive Cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) many years DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Severe obesity; mild uremia							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from February , 1960, to July 22 , 1960, that I last saw the deceased alive on July 22 , 1960, and that death occurred at 12:40 P. from the causes and on the date stated above ADDRESS (Street, city or town, state) Main Street DATE SIGNED							
ACTUAL SIGNATURE G. W. Meadors				M.D. Damascus, Maryland			
PHYSICIAN'S NAME (Type) G. W. Meadors, M.D.				Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/24/60		22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. McLaughlin				ADDRESS Damascus, Md.		24a. REC'D BY REGISTRAR DATE JUL 26 '60	
				24b. REGISTRAR'S SIGNATURE Olin L. McLaughlin			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

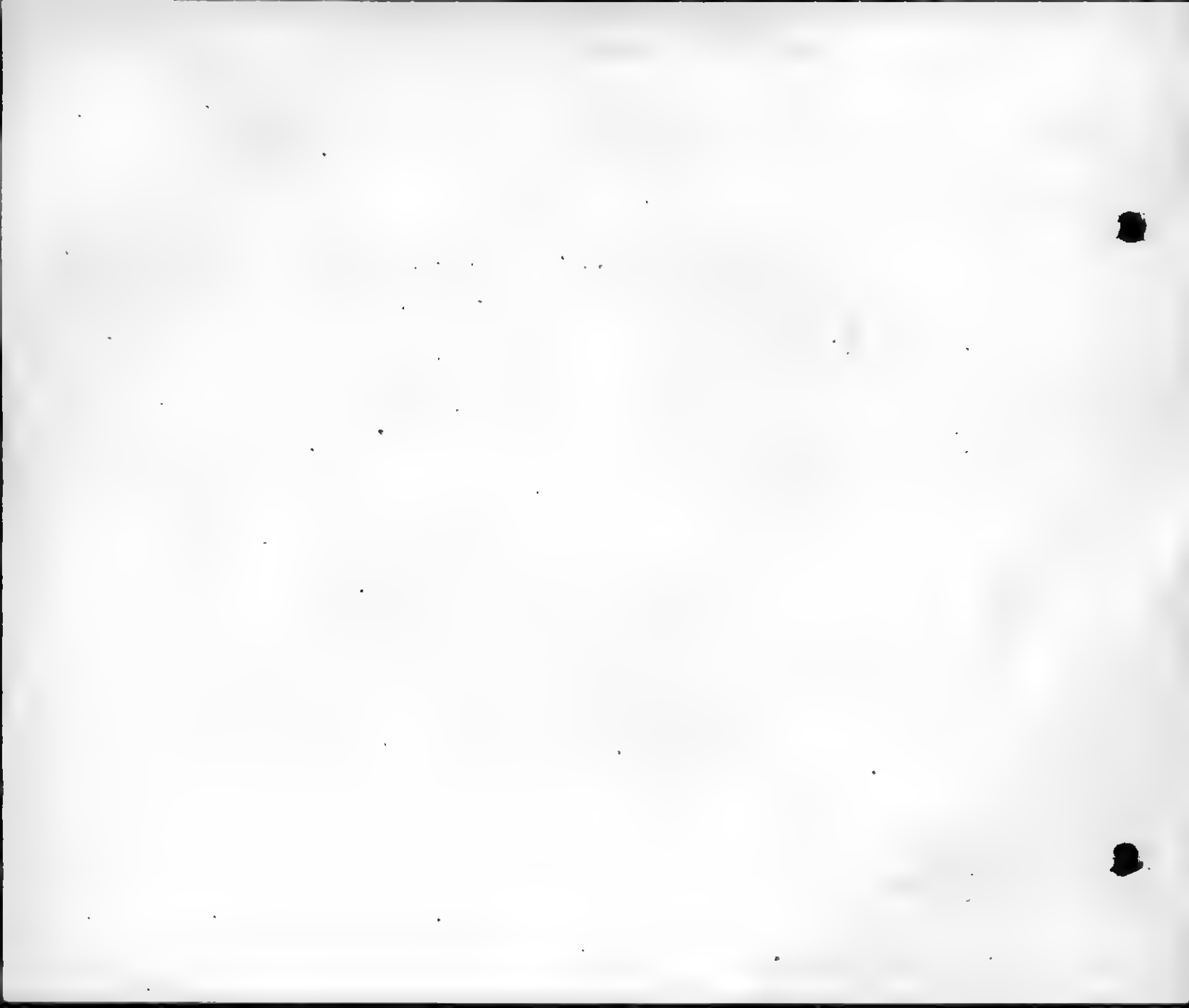
8228

CERTIFICATE OF DEATH

Reg. Dist. No.

08152

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMY KATHERINE GRADY</u>		4. DATE OF DEATH Month Day Year <u>July 15 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/22/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Not employed</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>WASH. D C</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM METZ</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE RENECKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Same as above</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Arteriosclerosis - Degenerative</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JANUARY 1960</u> to <u>JULY 15, 1960</u> , that I last saw the deceased alive on <u>JULY 15, 1960</u> and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sam Allen</u>		ADDRESS (Street, city or town, state) <u>WASH. D.C.</u> DATE SIGNED <u>7/15/60</u>	
PHYSICIAN'S NAME (Type) <u>SAM ALLEN, M.D.</u>			
22a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/>	22b. DATE THEREOF <u>7/18/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4812 92nd Ave NW</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 19 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kruse</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
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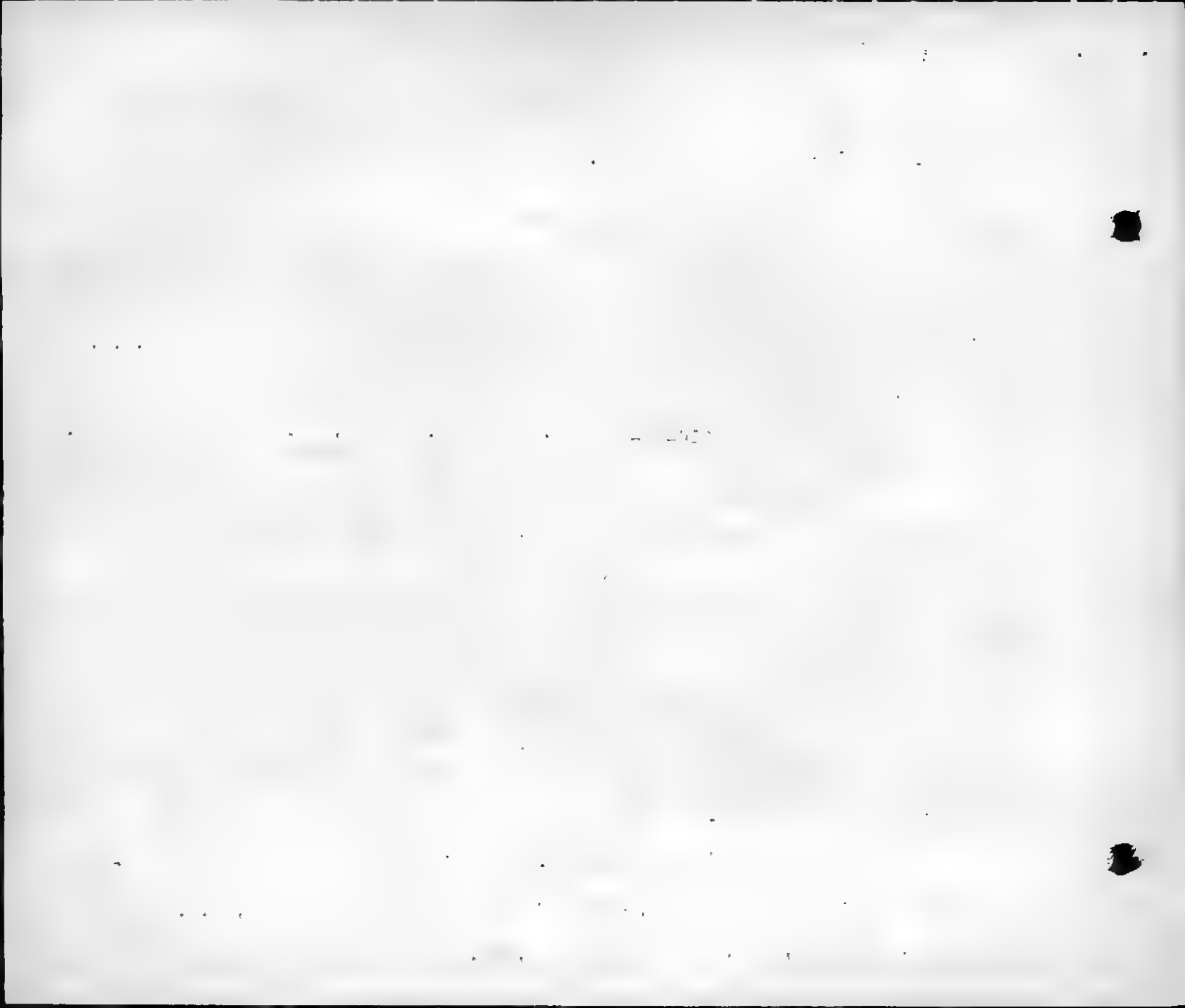
VR A15 (4)
15M 9/59

8113

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08153

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 29 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		d. STREET ADDRESS 2024 GLEN ROSS ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2024 GLEN ROSS ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUDREY Middle SPEAKE Last GRAHAM		4. DATE OF DEATH Month JULY Day 21 Year 19 60	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/03
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR: Months 21 Days 19 Hours 60 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWIN RAYMOND SPEAKE		14. MOTHER'S MAIDEN NAME LAVINIA BRAWNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-30-1118	
17. INFORMANT Mr. Daniel P. Graham, Sr.		Address 2024 Glen Ross Rd. Silver Spring, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO adenocarcinoma of ovary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH —	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1959 to July 21, 1960 that (I) (we) last saw the deceased alive on July 21, 1960 and that death occurred at 8 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J. Marion Bankhead		22b. DATE SIGNED July 26 '60	
22c. PHYSICIAN'S NAME (Type) J. Marion Bankhead		22d. ADDRESS 9241 Col. Blvd. Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/25/60	
23c. NAME OF CEMETERY OR CREMATORY ROCK CREEK CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Piska		25a. REC'D BY REGISTRAR Jul 26 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kneiss			



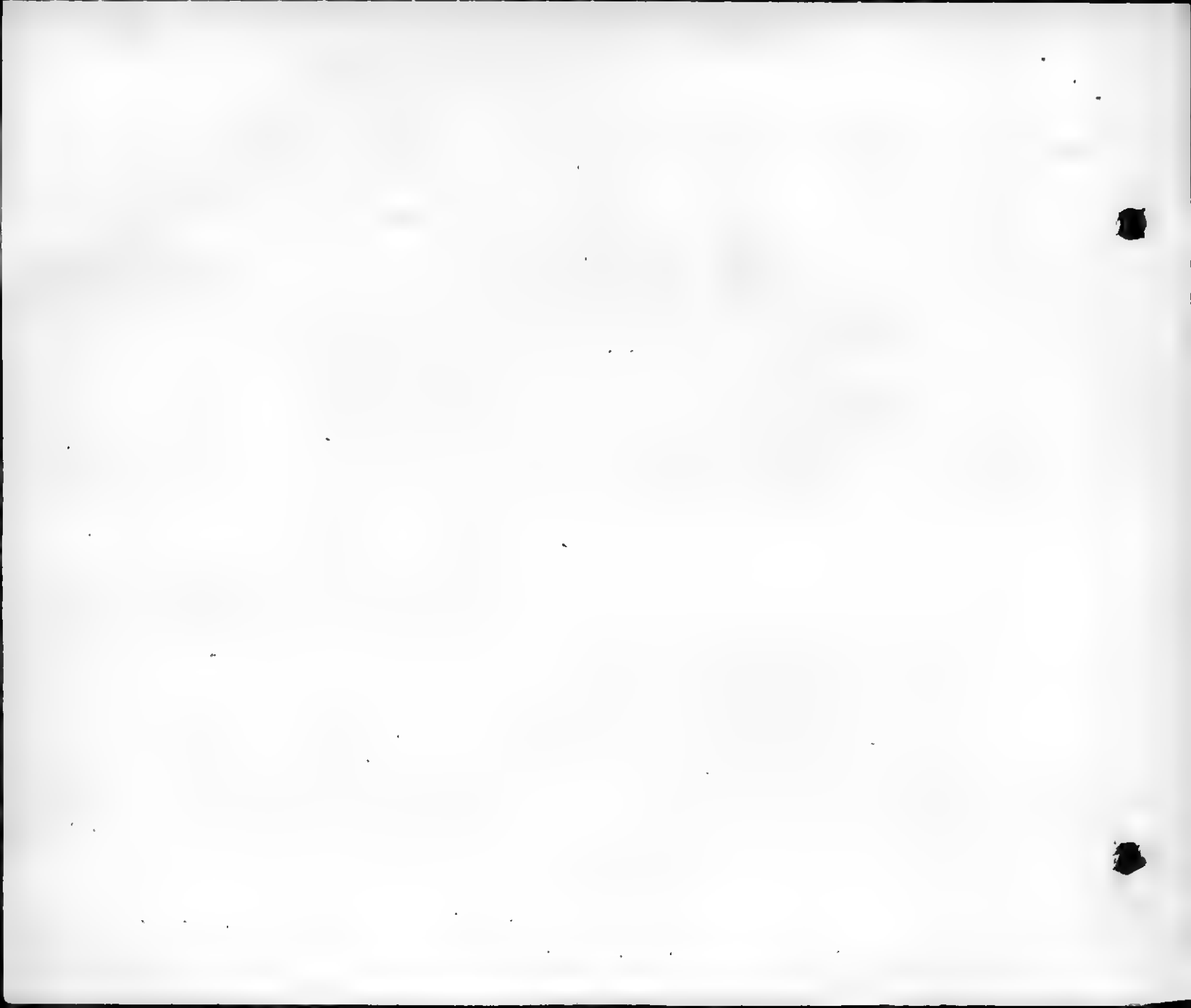
CERTIFICATE OF DEATH

Reg. Dist. No.

08154

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 19 hrs.			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Suburban Hos pital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Florence Middle Marie Last Graham				4. DATE OF DEATH Month July Day 5 Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1891	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 6 Days 16 Hours 16 Min		11. BIRTHPLACE (State or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -----			
13. FATHER'S NAME Gus Wisener				14. MOTHER'S MAIDEN NAME Ella Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)) No				16. SOCIAL SECURITY NO. 577-05-2053			
17. INFORMANT Neil Graham-Husband-				Address 5315 Glenwood Road Bethesda, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Failure DUE TO Hypertensive Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) 5 YRS (c) 24 HRS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 7, 1960 to July 5, 1960 , that I last saw the deceased alive on July 5, 1960 , and that death occurred at 6 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo I Donovan M.D.				ADDRESS (Street, city or town, state) 8218 Wisconsin Ave DATE SIGNED 7/5/60			
PHYSICIAN'S NAME (Type) LEO I DONOVAN MD				BETHESDA 14 MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland			
24a. REC'D BY REGISTRAR JUL 7 '60				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

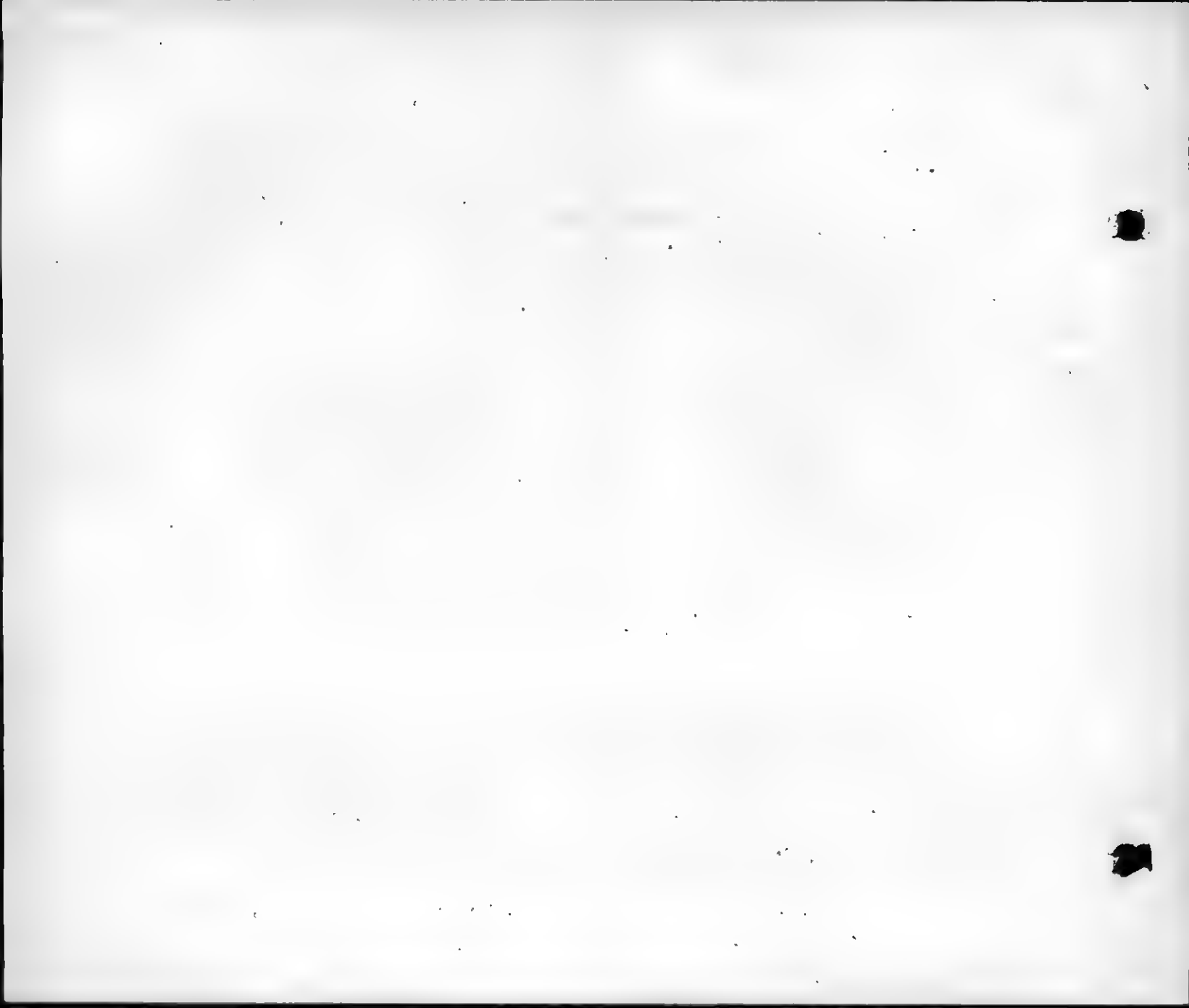
08155

8230

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. COUNTY <i>Mont.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>15049 Bradley Blvd.</i>	
3. NAME OF DECEASED (Type or print) <i>UNNAMED</i> First <i>Infant Boy</i> Middle <i>Grant</i> Last <i>Grant</i>		4. DATE OF DEATH <i>July 26 1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 26, 1960</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <i>11</i> Months <i>11</i> Days <i>11</i> Hours <i>11</i> Min
11. BIRTH PLACE (State or foreign country) <i>Mont. Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Raymond E. Grant</i>		14. MOTHER'S MAIDEN NAME <i>Stallie Ann Bender</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Sts. Chart.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Respiratory failure, undetermined Cause</i> <i>769.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>11 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Maternal diabetes</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>7/26</i> , 1960, to <i>7/26</i> , 1960, that I last saw the deceased alive on <i>7/26</i> , 1960, and that death occurred at <i>7:25 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John E. Cassidy</i>		ADDRESS (Street, city or town, state) <i>7911 Georgetown Rd. Bethesda 7/26/60</i>	
PHYSICIAN'S NAME (Type) <i>JOHN E. CASSIDY</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>7/29/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>ARLINGTON NAT'L. CEMETERY</i>	22d. LOCATION (City, town, or county) (State) <i>ARLINGTON, VIRGINIA</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner F. Humphrey, Inc.</i>		24a. REC'D BY REGISTRAR <i>DATE JUL 29 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board at Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8231

08156

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home				d. STREET ADDRESS 106 Lynch Street			
3. NAME OF DECEASED (Type or print) First Israel Middle B. Last Grossman				4. DATE OF DEATH Month 7 Day 16 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 19, 1887	
9. AGE (In years last birthday) 72 yr		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Grocery store		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Louis Grossman				14. MOTHER'S MAIDEN NAME Dora			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant cachexia 1577 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma of Liver DUE TO (c) Carcinoma of Pancreas							
INTERVAL BETWEEN ONSET AND DEATH 4 wks 4 months 1 year							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While o. work <input type="checkbox"/> Not while o. work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 26, 1956 , to July 16, 1960 , that (I) (we) last saw the deceased alive on July 15, 1960 , and that death occurred at 6:10 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Robert G. Angle				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 1960	
22c. PHYSICIAN'S NAME (Type) Robert G. Angle				22d. ADDRESS 5009 Del Ray Ave.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF July 17/60		23c. NAME OF CEMETERY OR CREMATORY Anshe Emurah		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Isidore L. Grossman				ADDRESS 6010 Cent. Rd.		25a. REC'D BY REGISTRAR DATE JUL 18 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kenna			



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

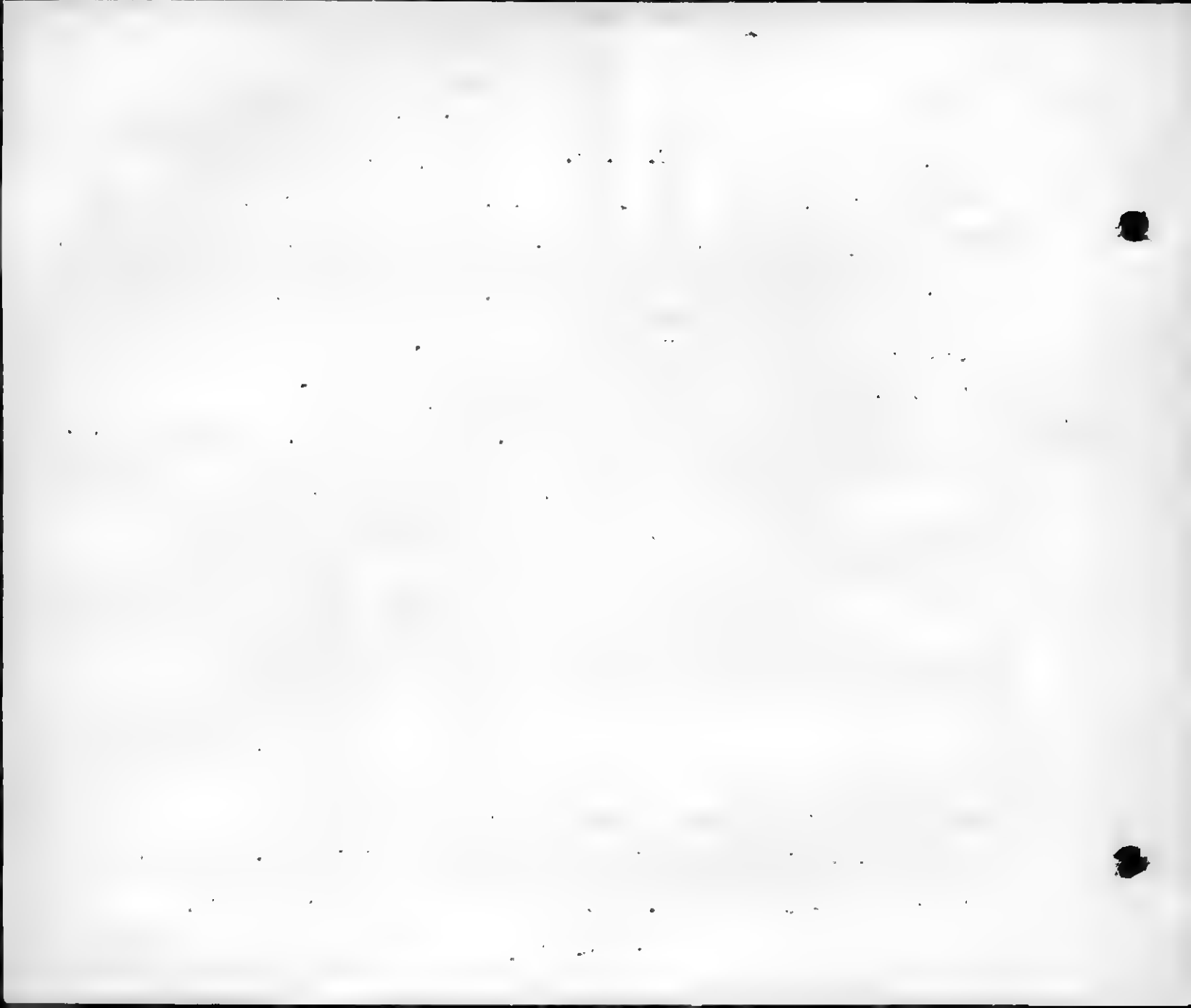
8232

CERTIFICATE OF DEATH

08157

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>D. O. A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Richard</u> Last <u>Gue</u>				4. DATE OF DEATH Month <u>July</u> Day <u>26</u> Year <u>60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1882</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Gue</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Young</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>Mrs. Edna Gue Rt. #2 Gaithersburg</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Acute Coronary</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY</u> , 19 <u>55</u> , to <u>7-26</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-12</u> , 19 <u>60</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>7-27-60</u> ACTUAL SIGNATURE <u>Jack Schumacher</u> M.D. PHYSICIAN'S NAME (Type) <u>Dr. Jack Schumacher</u> <u>Gaithersburg, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL, or other disposal <u>Burial</u>		22b. DATE THEREOF <u>7-28-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Etchison, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Mytonsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 29 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

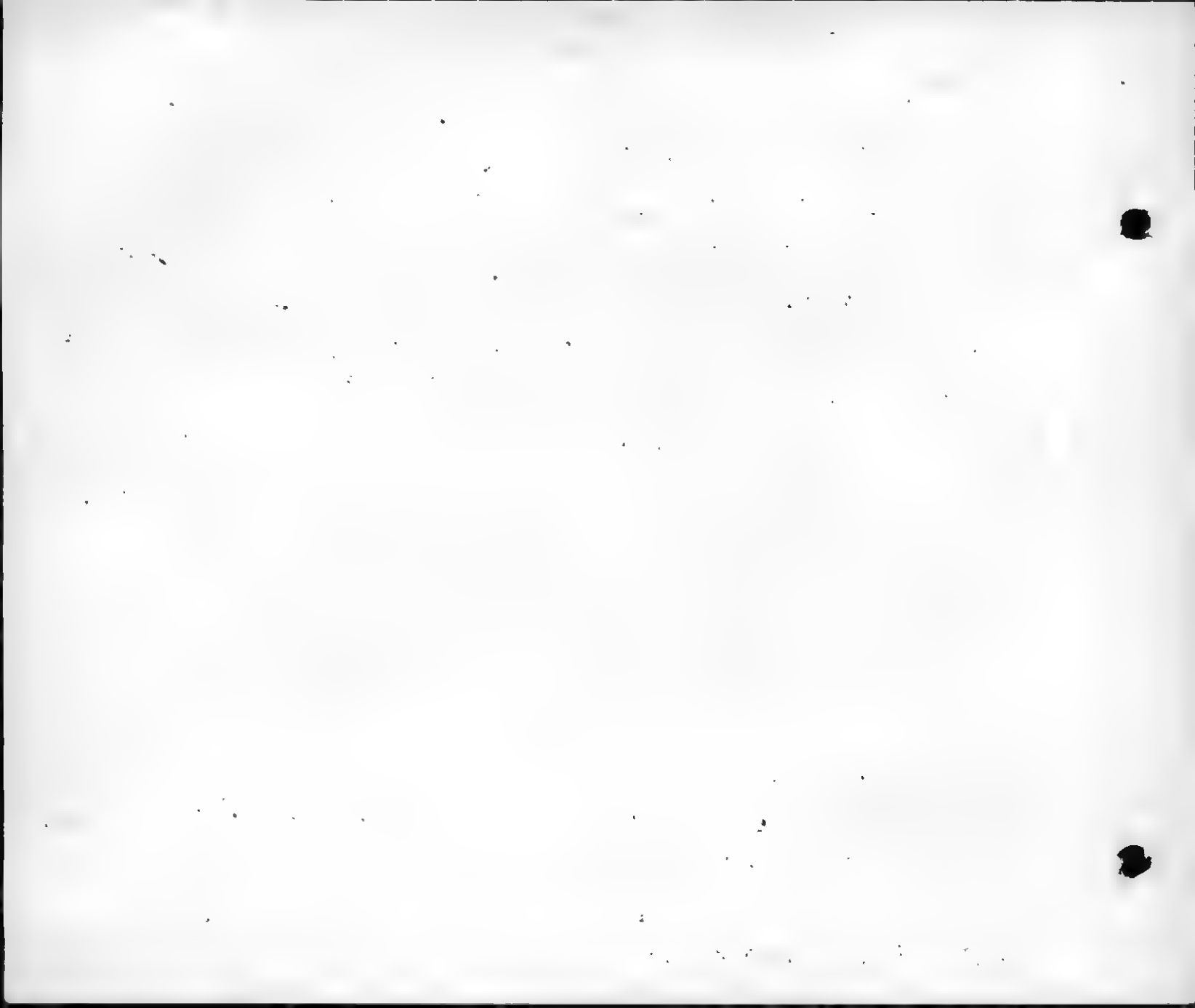
8233

CERTIFICATE OF DEATH

08155

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>11543 - N. Falkland Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Gumme</u> Last <u>L</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 18, 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>1</u> Hours <u></u> Min <u></u>		11. AGE (In years last birthday) <u>82</u> yrs.		12. IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Edward G. Gumme</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Kiefert</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>yes-unknown</u>			
17. INFORMANT <u>Frances Pearl Gumme</u>				Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 13, 1960</u> to <u>19 July, 1960</u> that I last saw the deceased alive on <u>12 pm</u> <u>1960</u> and that death occurred at <u>5:40 PM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace W. Burnton</u>				ADDRESS (Street, city or town, state) <u>10511 Summit Ave</u>			
PHYSICIAN'S NAME (Type) <u>Horace W. Burnton</u>				DATE SIGNED <u>Kinsington, Md. 7/19/60</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/22/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 22 '60</u>	
						24b. REGISTRAR'S SIGNATURE <u>William J. Howard</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

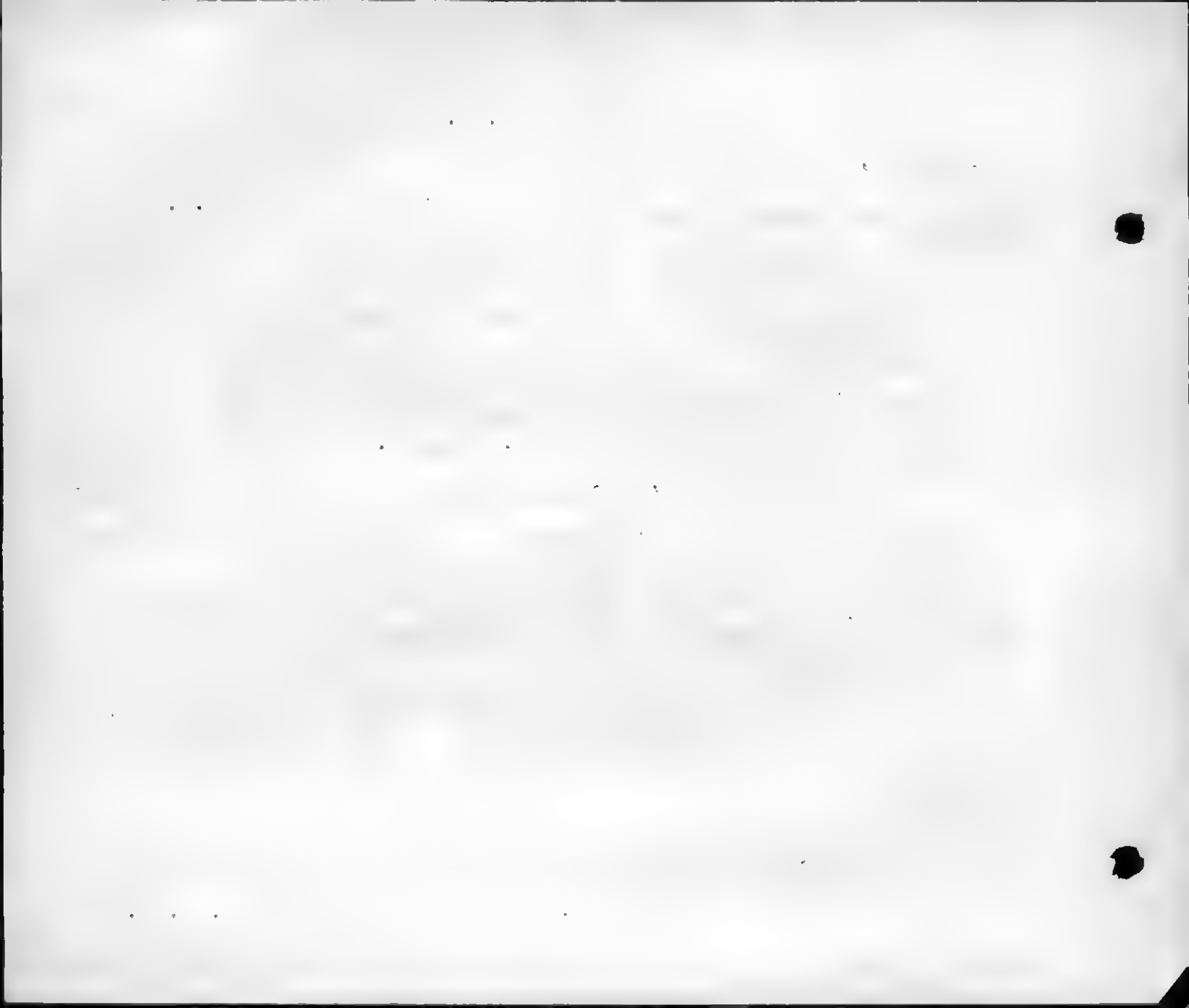
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

8172

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08159

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanitarium</u>				d. STREET ADDRESS <u>4440 Burlington Place N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Hall</u> Last <u>Hall</u>				4. DATE OF DEATH Month <u>July</u> Day <u>19</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 30 1868</u>	9. AGE (In years last birthday) <u>92</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>James Vanhook</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Frank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mrs. Ethel H. Ashman same as #2D</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Septicemia</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>gent arteriosclerosis, Mesenteric thrombosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 19, 1951</u> to <u>July 19, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 19, 1960</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert W. Sjogren</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-19-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert W. SJOGREN</u>				22d. ADDRESS <u>1835 Eye St. N.W., Washington, D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/22/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maple Ave. Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Fultonville, N. Y.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>S. H. Hines Co. 2901 14th St. N.W., Wash, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 21 1960</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hines</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

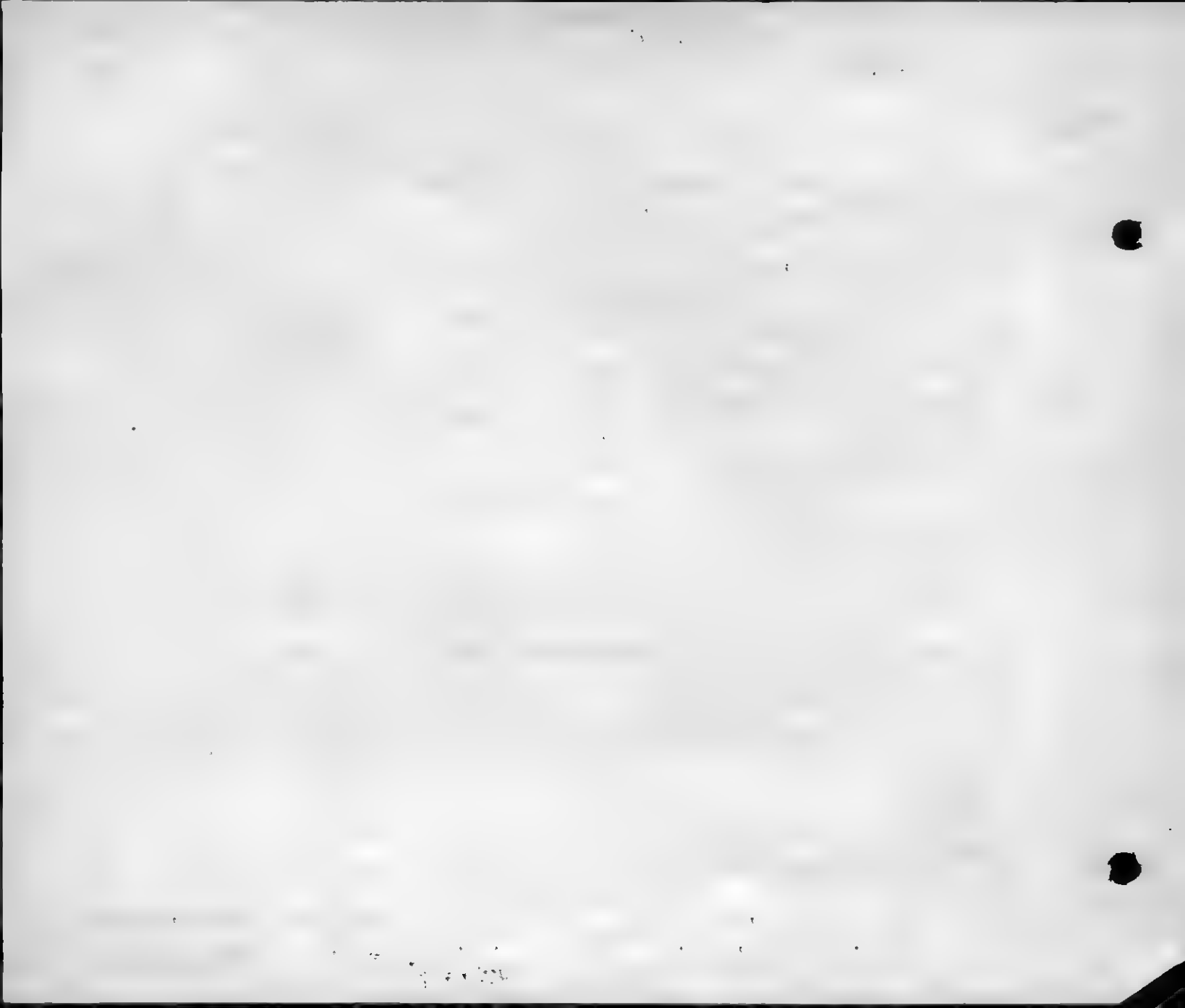
8139

08160

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>1 hr 10 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASIT. SAN & Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> d. STREET ADDRESS <u>7614 Blair Rd</u>			
3. NAME OF DECEASED (Type or print) <u>GILBERTA CATHERINE HAMPTON</u>		4. DATE OF DEATH <u>7-7-1960</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-12</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR: Months <u>4</u> Days <u>7</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>JOHN FRANK BAILEY</u>		14. MOTHER'S MAIDEN NAME <u>ALBERTA MARIE LONG</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-24-8847</u>		17. INFORMANT <u>JAMES E GRAVES</u> Address <u>2607 KICKWOOD PL. W. H. YATTON</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>							
Conditions, if any, which gave rise to immediate cause (b) _____							
(a), stating the underlying cause last. (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-7-60</u>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JULY 11, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>			
				22d. LOCATION (City, town, or county) <u>MONTGOMERY COUNTY, MARYLAND</u>			
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u>		24a. REC'D BY REGISTRAR <u>Raymond A. Ziska</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs



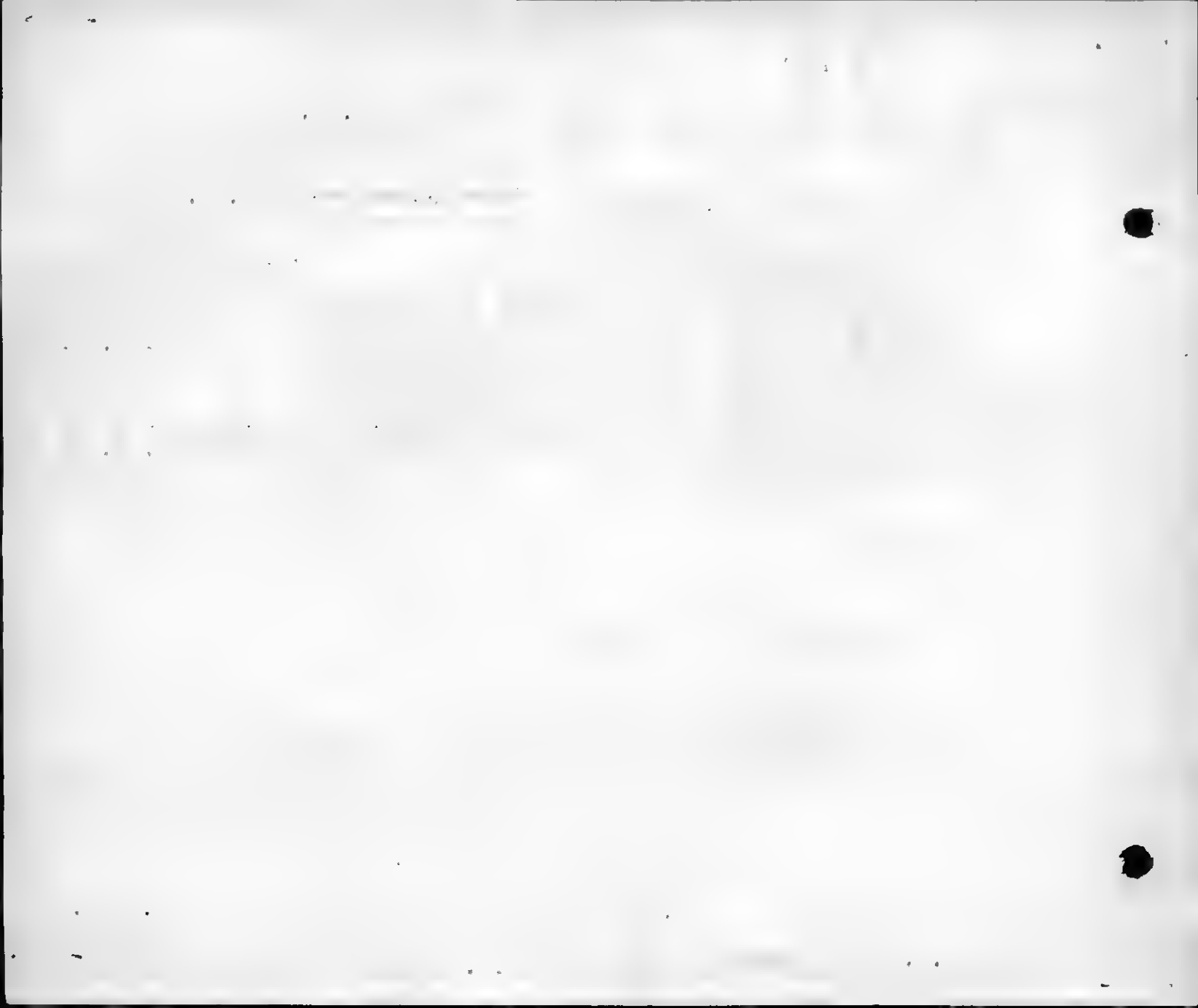
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8173

CERTIFICATE OF DEATH

Reg. Dist. No. 08161

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY D. C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENSINGTON GARDENS SANITARIUM		d. STREET ADDRESS 3219 Macomb Street N. W.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY E HARDIE		4. DATE OF DEATH Month Day Year JULY 4 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 24 76
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ISSAC KLINE		14. MOTHER'S MAIDEN NAME MARY EYRE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] no		16. SOCIAL SECURITY NO. none	
17. INFORMANT HELEN WINFIELD		Address 3219 MACOMB ST NW Washington, D. C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia, right, acute DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Embolism from left heart DUE TO (c) Auricular fibrillation		INTERVAL BETWEEN ONSET AND DEATH 16 hrs. 16 hrs. 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, general advanced		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 29, 1959, to July 4, 1960, that I last saw the deceased alive on July 4, 1960, and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) DATE SIGNED 4740 Chevy Chase Dr. 7-5-60	
PHYSICIAN'S NAME (Type) Stewart Clapp M.D. Chevy Chase, Md.			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/7/60	22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	22d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company		ADDRESS 2901 14 ST NW WASHINGTON D.C.	
24a. REC'D BY REGISTRAR JUL 6 '60		24b. REGISTRAR'S SIGNATURE William S. Hines	



may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8234

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08162

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>12 Da.</u>				d. STREET ADDRESS <u>9220 Kingsbury Dr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove foundation</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Dorothea</u> First <u>Ohl</u> Middle <u>Hardy</u> Last				4. DATE OF DEATH <u>July</u> Month <u>27</u> Day <u>1960</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucas</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 25, 1884</u> <u>77</u> yrs	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Teacher (retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public Schools</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>							
13. FATHER'S NAME <u>Hibert Ohl</u>				14. MOTHER'S MAIDEN NAME <u>Dorothea Morris</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT <u>Hibert & Hardy</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive and arteriosclerotic heart disease</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 1</u> 19 <u>57</u> , to <u>July 27</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>July 24</u> 19 <u>60</u> , and that death occurred at <u>2:10 PM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Aaron H. Traum</u>				22b. DATE SIGNED <u>July 27 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>AARON H. TRAUM</u>				22d. ADDRESS <u>8237 Ga. Ave., Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>TRANS. & BURIAL</u>		<u>7/29/60</u>		<u>Ohltown Cemetery</u>		<u>Trouble County, Ohio</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>DATE AUG 1 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



8235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>1804 Lanark Way</u>	
3. NAME OF DECEASED (Type or print) First <u>E.</u> Middle <u>Glendon</u> Last <u>Harmon</u>		4. DATE OF DEATH Month <u>July</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 31 1912</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Parts</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Hubert H. Harmon</u>	
14. MOTHER'S MAIDEN NAME <u>Schmidt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>232-10-0173</u>		INFORMANT <u>Marie B. Harmon</u> Address <u>5009 Del Ray Ave. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Posterosiwall, Left ventricle</u> 420.1 DUE TO <u>Thrombosis, Posterior coronary artery</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Coronary Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ORGANOMEGALY, OBESITY, DIABETES MELLITUS</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 10</u> , 19 <u>60</u> to <u>July 11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 11</u> , 19 <u>60</u> , and that death occurred at <u>3:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert G. Angle</u>		ADDRESS (Street, city or town, state) <u>5009 Del Ray Ave. Bethesda, Md.</u> DATE SIGNED <u>7/12/60</u>	
PHYSICIAN'S NAME (Type) <u>Robert G. Angle</u>		5009 Del Ray Ave, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/15/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kincaid</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08164

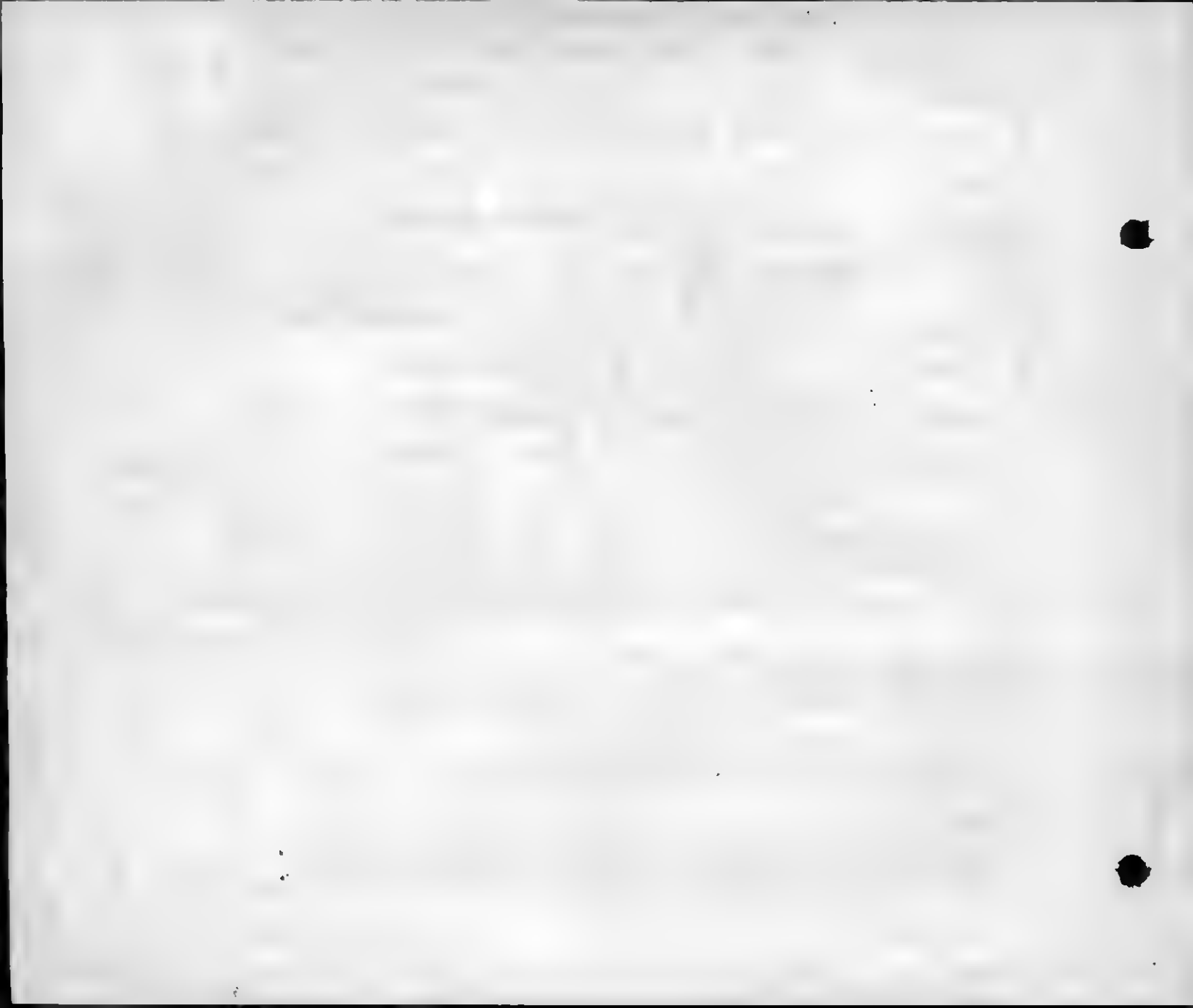
Reg. Dist. No.

8163

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
c. LENGTH OF STAY IN 1b <u>6 yrs</u>				d. STREET ADDRESS <u>1104 Tulip Dr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 Tulip Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Loretta</u> <u>Powers</u> <u>Hartley</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>6</u> <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-26-91</u>	
9. AGE in years last birthday <u>68</u> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-C</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Thos. Nicholas Powers</u>				14. MOTHER'S MAIDEN NAME <u>Susan Gardick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Dorothy Ullman</u>				Address <u>Stem 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary Atherosclerosis</u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 day</u> <u>9 years</u></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)</p>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broesch</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BROESCH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8 July 60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Smith</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. K...</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8140
CERTIFICATE OF DEATH

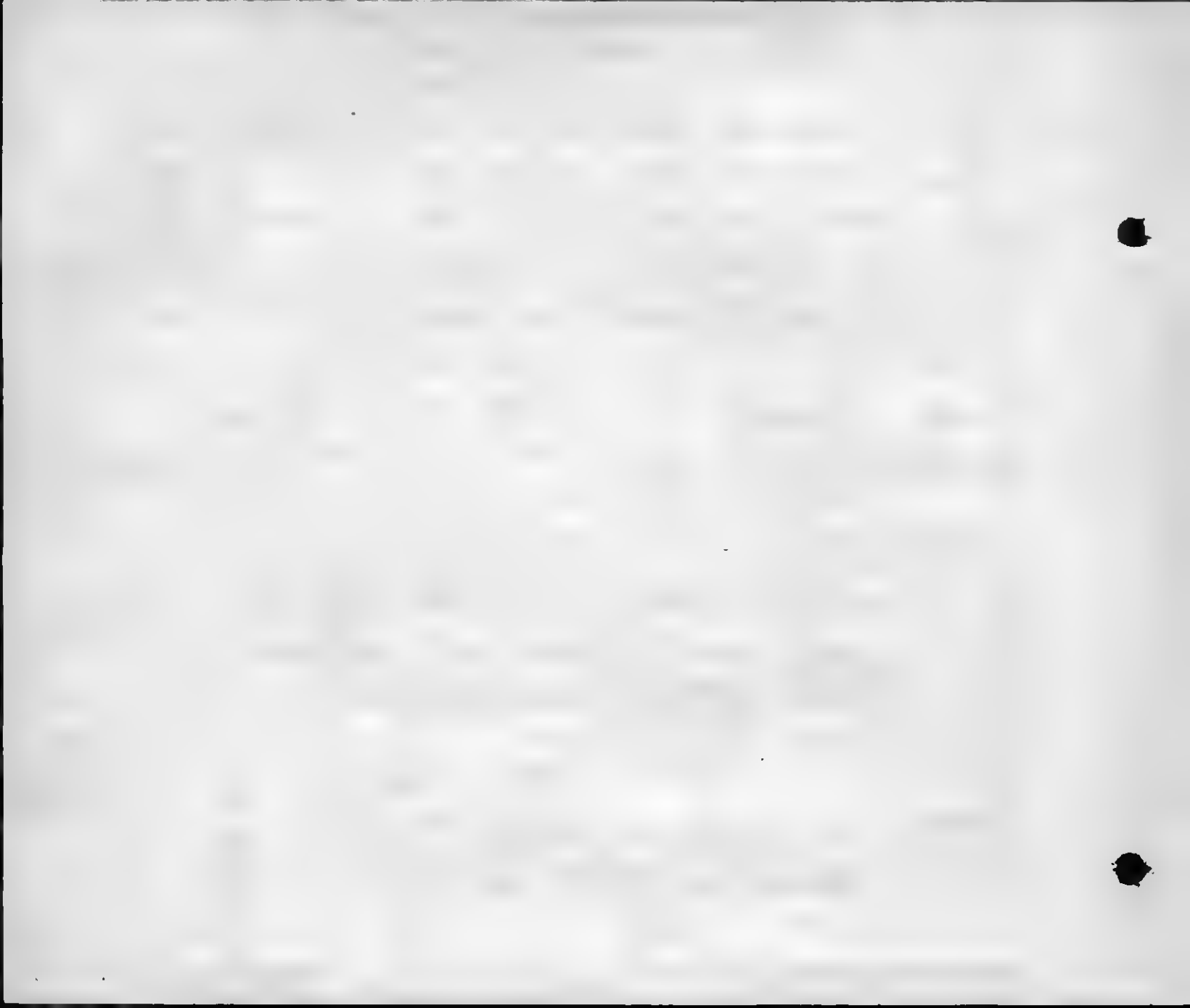
08165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sant Hosp</u>				e. STREET ADDRESS <u>403 Beech Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Hartung Carl (NMN) Hartung Jr.</u>				4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>11-3-83</u>	9. AGE (In years last birthday) <u>76</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paint & Hardware</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Carl Hartung Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Wrenzt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hem. & Hemiplegia</u> (1st 7/10/60 - 2nd 7/13/60) DUE TO (b) <u>Rt. Broncho pneumonia</u> 7/13/60 DUE TO (c) <u>Suicide attempt (Chloroform)</u> 7/10/60 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/28/54</u> , 19 <u>54</u> , to <u>7/13/60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7/13/60</u> , 19 <u>60</u> , and that death occurred at <u>3:10</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7030 Carroll Ave</u> DATE SIGNED <u>7/15/60</u> ACTUAL SIGNATURE <u>Howard T. Morse</u> M.D. <u>Takoma Park, Md.</u> PHYSICIAN'S NAME (Type) <u>Howard T. Morse M.D.</u> <u>Takoma Park, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>July 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Prince Geo. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 19 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

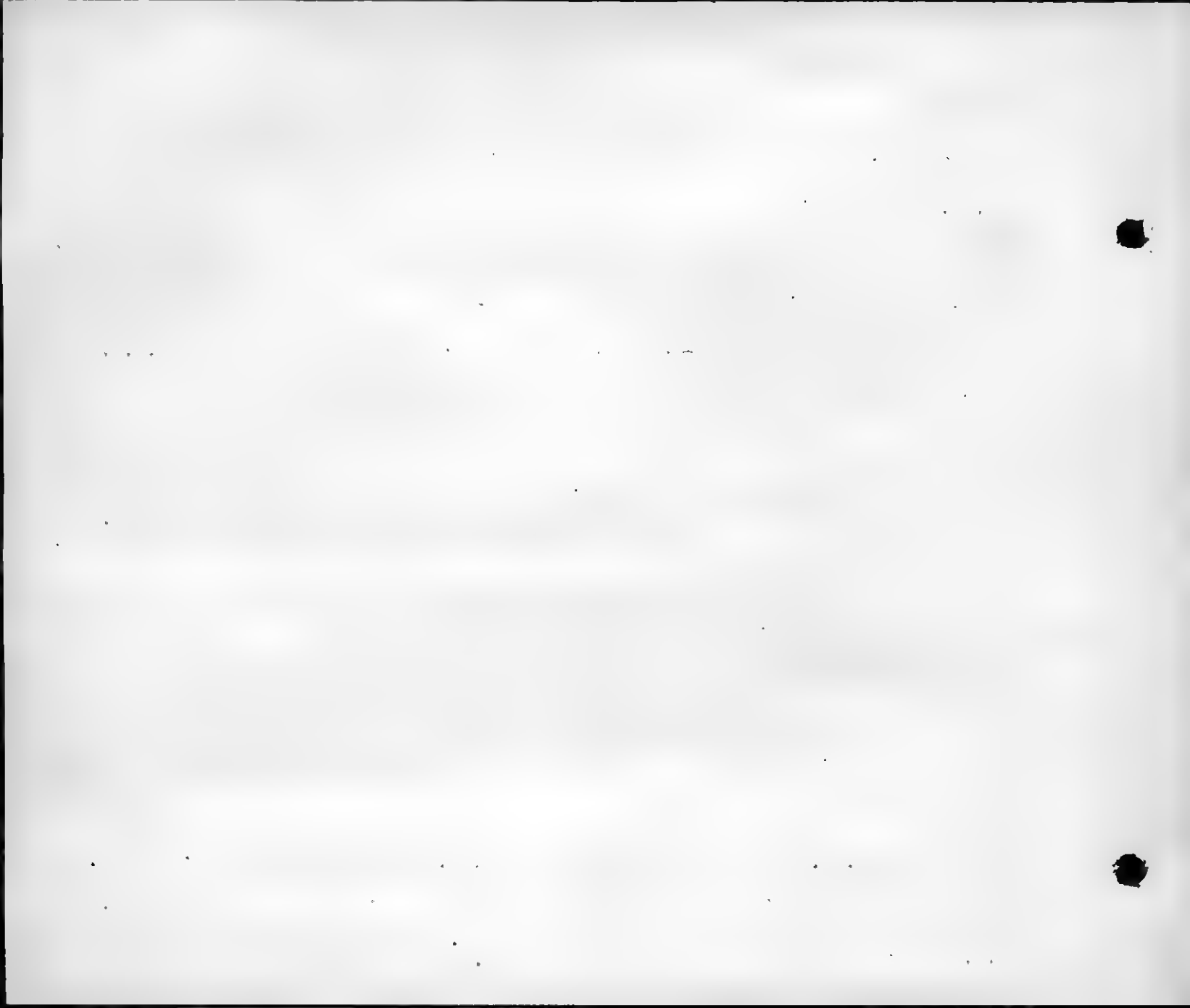


MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8236

08166

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 5607 Seminole Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Evelyn M HATFIELD			4. DATE OF DEATH Month Day Year July 7 19 60				
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-27-13	9. AGE (In years last birthday) 46 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) New Jersey			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Ernest NOENNICH				
14. MOTHER'S MAIDEN NAME Edith NOTTOFF			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO.			17. INFORMANT Hospital Records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus - 3 years +					INTERVAL BETWEEN ONSET AND DEATH 17 days Unknown		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (his hospital) attended the deceased from July 1, 1960 to July 7, 1960 , that (I) (we) saw the deceased alive on July 7, 1960 , and that death occurred at 1:30 PM from the causes and on the date stated above.							
22a. SIGNATURE F. S. Caldwell			22b. DATE SIGNED 7-8-60		22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL, LT, MC, USN		
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			23a. BJR AL, CREMATION, REMOVAL (Specify) Burial				
23b. DATE THEREOF 7-11-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers			25a. REC'D BY REGISTRAR Jul 12 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Hines		



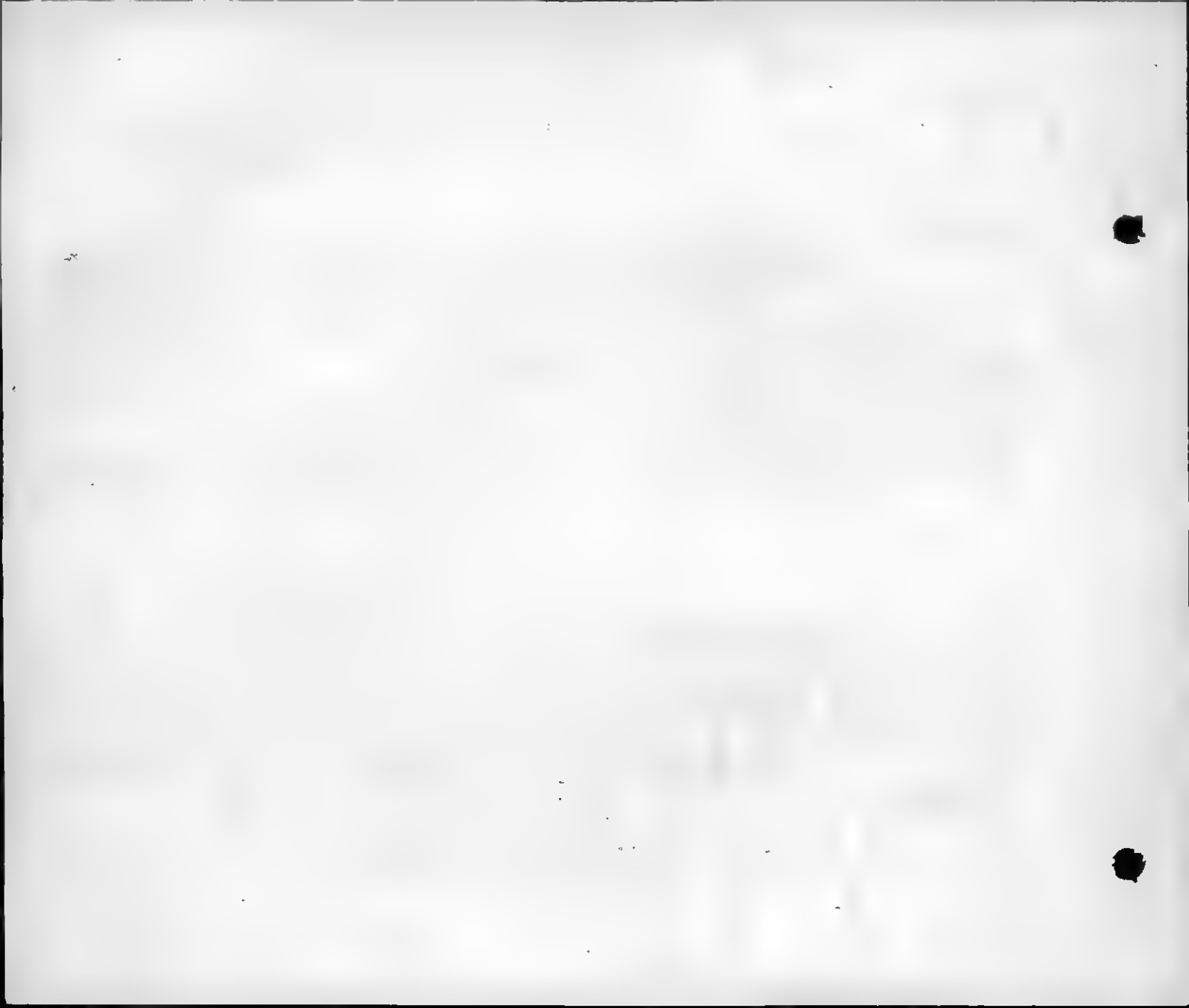
may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08167

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u> c. LENGTH OF STAY IN lb <u>2 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. & Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwyn Heights</u> d. STREET ADDRESS <u>6012 Quebec St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Hefferman</u>				4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-5-16</u>	
9. AGE (In years last birthday) <u>43</u> yrs		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Warehouse Mgr.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Furniture</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Matthew Hefferman</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Louis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W. 2 071-01-3384</u>		17. INFORMANT <u>Pl's Chart</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive cerebral hemorrhage</u> DUE TO <u>460x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Corrosion of liver</u> DUE TO <u>2 year</u> (c) <u>Bleeding Esophageal Varices</u> DUE TO <u>2 yrs -</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Chronic alcoholism & arteriosclerosis -</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 1945</u> to <u>7-18, 1960</u> , that (I) (we) lost the deceased alive on <u>7-18-1960</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>N.C. Shoemaker M.D.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>N.C. SHOEMAKER, MD</u>				22d. ADDRESS <u>8005 Woodbury Dr. Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-22-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chambers Co Riverdale Md</u>				25a. REC'D BY REGISTRAR <u>JUL 26 1960</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

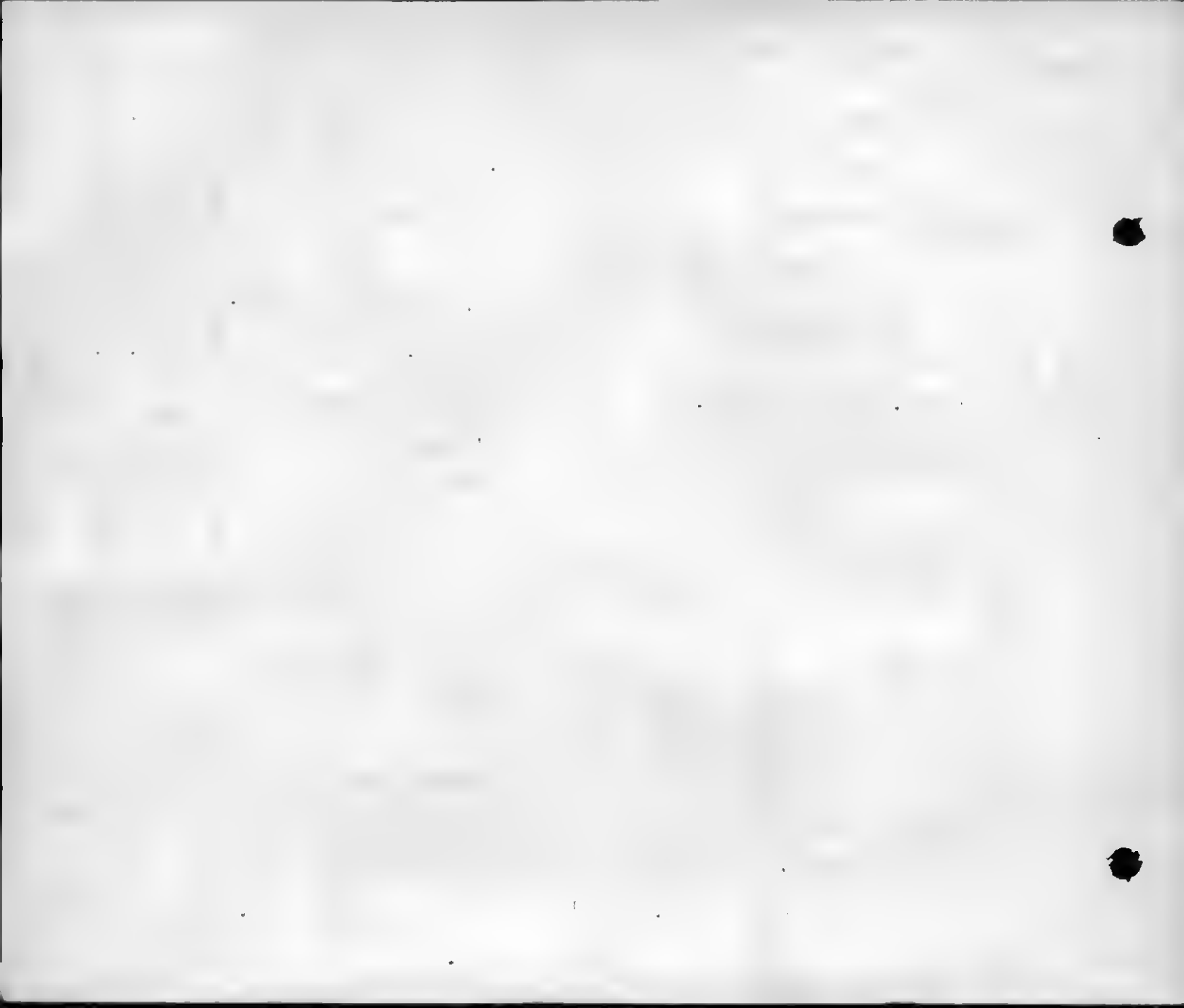


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME
SM 2/57

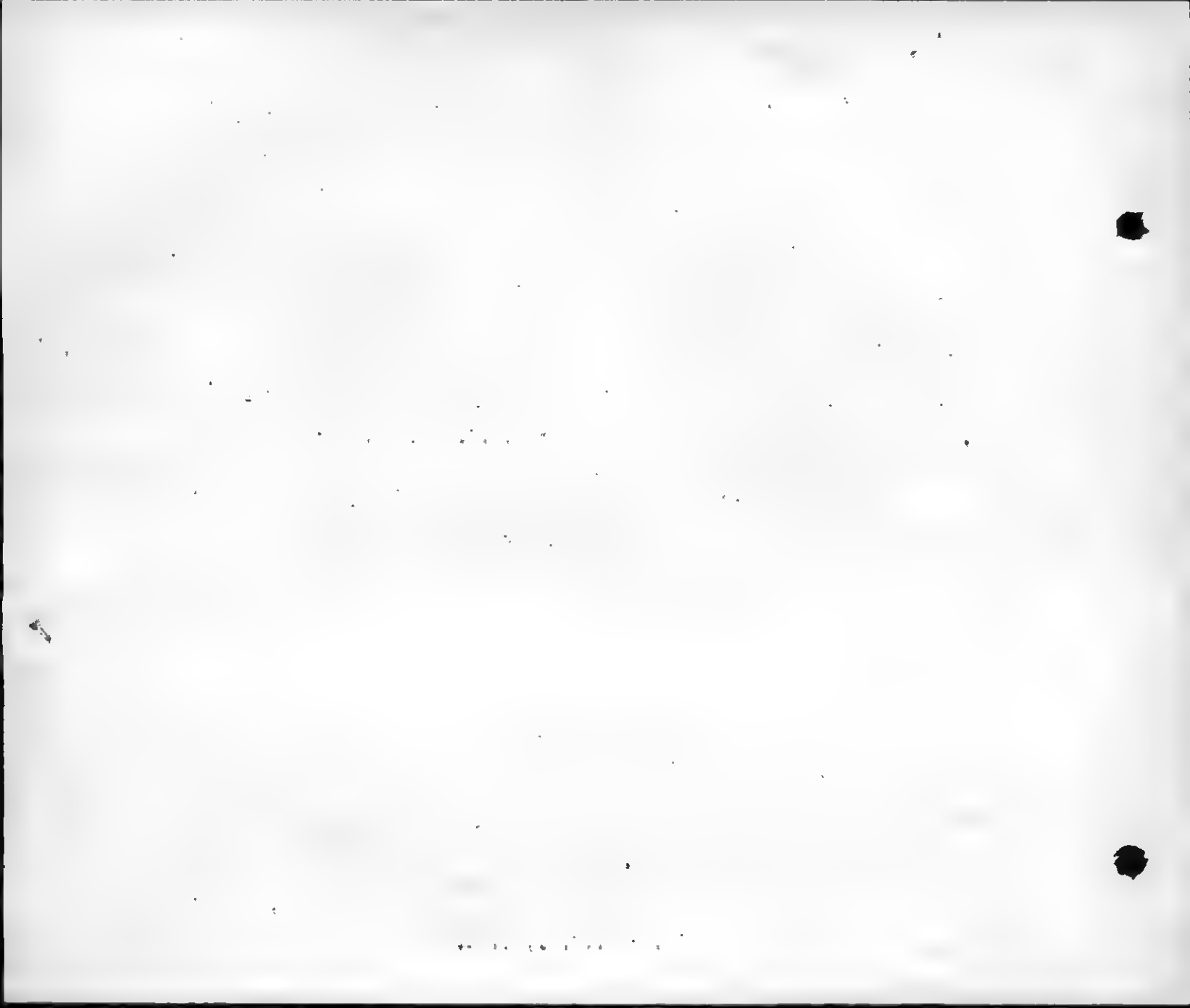
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
8237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 08168										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Mont.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 24 hrs 20 min s.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban					d. STREET ADDRESS 4408- Great Oak Rd. -Manor Club				e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles Howard Lockwood Hines					4. DATE OF DEATH July 26 19 60					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 24, 1954		9. AGE (In years last birthday) 5 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mont. Co.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME C. Calvert Hines Jr.					14. MOTHER'S MAIDEN NAME Janet Stanley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Pt's Chart Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Contusion 8/13 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Rode bike in front of car - laceration of jaw - unconscious								
20c. TIME OF INJURY Month, Day, Year 6:00 p.m. 7/25 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Rockville (County) Montg (State) Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE John G. Ball					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) John G. Ball					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED 26 July 60										
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 7-28-60		22c. NAME OF CEMETERY OR CREMATORY St. John's Episcopal		22d. LOCATION (City, town, or county) Olney, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber					ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JUL 29 60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
8116											
CERTIFICATE OF DEATH											
Reg. Dist. No. 08169											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY Co. MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>N.W.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>						c. LENGTH OF STAY IN 1b <u>6 mo</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Althea Woodland N.H.</u>						e. STREET ADDRESS <u>9301 Weaver St</u>					
3. NAME OF DECEASED (Type or print) <u>Mary CASSEL Holloway</u>						4. DATE OF DEATH <u>7 13 1960</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-21-1881</u>		9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>				11. BIRTHPLACE (State or foreign country) <u>PA.</u>			
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>											
13. FATHER'S NAME <u>Henry Burd Cassel</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ann Patterson</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>NONE</u>					
17. INFORMANT <u>Mrs. H. C. Torbert, SAME AS # 2</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia (terminal)</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>united hip fracture</u>											
(c) <u>-----</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <u>19</u>						20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>48</u> , to <u>7-13</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-11</u> , 19 <u>60</u> , and that death occurred at <u>1:38</u> M, from the causes and on the date stated above											
ACTUAL SIGNATURE <u>Hill Carter</u>						ADDRESS (Street, city or town, state) <u>1835 Eye St NW Wash 6 DC</u>					
NAME (Type) <u>HILL CARTER</u>						DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>7/16/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Marietta Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>MARIETTA, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gaudin</u>						24a. REC'D BY REGISTRAR <u>DATE JUL 14 '60</u>					
ADDRESS <u>1756 PA. AVE., N.W., D. C.</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>					



8238

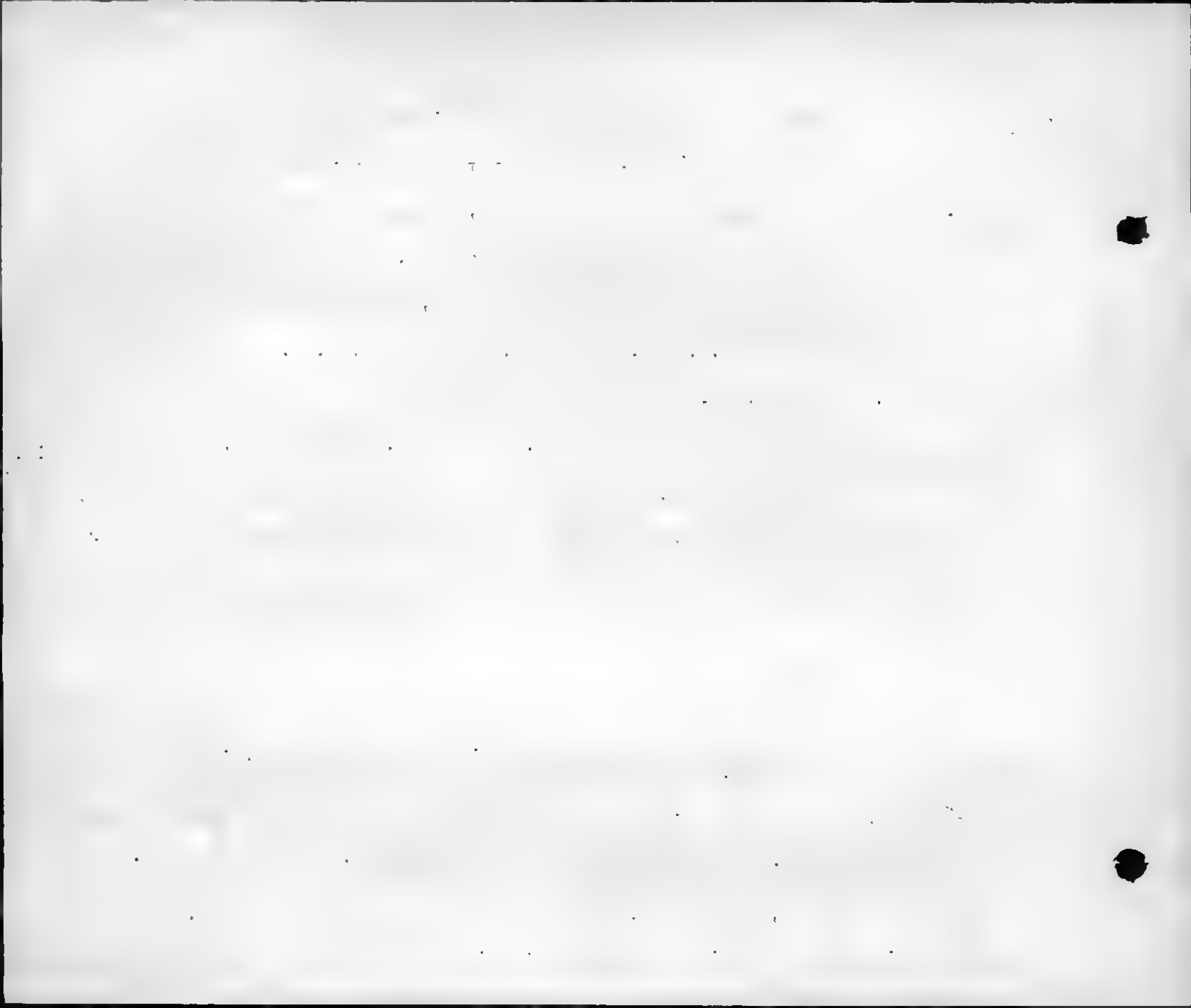
CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08170

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Norbeck		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Philomena Nursing Home		e. STREET ADDRESS 12,609 Atherton Drive	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Eugene Joseph Hourihane SR.		4. DATE OF DEATH Month Day Year July 10 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 17, 1897
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.-Navy Dept.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene J. Hourihane, Sr.		14. MOTHER'S MAIDEN NAME Sarah Mullen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW #1		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Gertrude M. Hourihane,		Address 12,609 Atherton Dr. S. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis, acute 4-2-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH one hour 5 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1956 to July 10, 1960 , that (I) (we) last saw the deceased alive on July 6 1960 and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE HARRY J. KICHERER		22b. DATE SIGNED July 10, 1960	
22c. PHYSICIAN'S NAME (Type) HARRY J. KICHERER		22d. ADDRESS 5527 Surry St., Chevy Chase, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 13, 1960	
23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY		23d. LOCATION (City, town, or county) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. Raymond A. Ziska		25a. REC'D BY REG. STRAR DATE JUL 14 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon 1 and 2 and fill with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8117

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0817

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN (b) MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Reddix Res., Fairland Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring d. STREET ADDRESS 1237 Colesville-Beltsville Rd.			
3. NAME OF DECEASED (Type or print) Linwood Jackson		4. DATE OF DEATH July 2, 1960		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX male	6. COLOR OR RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1938	9. AGE (In years last birthday) 22 IF UNDER 1 YEAR: Months 22 Days 22 Hours 22 M.n. 22			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) USA			
13. FATHER'S NAME Benjamin Jackson			14. MOTHER'S MAIDEN NAME Grace Jackson				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. Ernest Jackson (uncle)		17. INFORMANT 124 Colesville-Beltsville Rd. Silver Spring			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination DUE TO (b) Separation of heart & aorta DUE TO (c) Gunshot wounds of thorax CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot in chest- accused unknown					
20c. TIME OF INJURY Month. Day. Year 1:30 a.m. 7/2/60		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home			
20f. (City or town) Silver Spring		(County) Montg.		(State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 7/2/60			
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/6/60		22c. NAME OF CEMETERY OR CREMATORY Good Hope.,			
22d. LOCATION (City, town, or country) Colesville, Md.		23. FUNERAL DIRECTOR Robert L. Gunder		ADDRESS Rockville, Md.			
24a. REC'D BY REGISTRAR JUL 6 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines					

4 JAN 1934

Benjamin Jackson

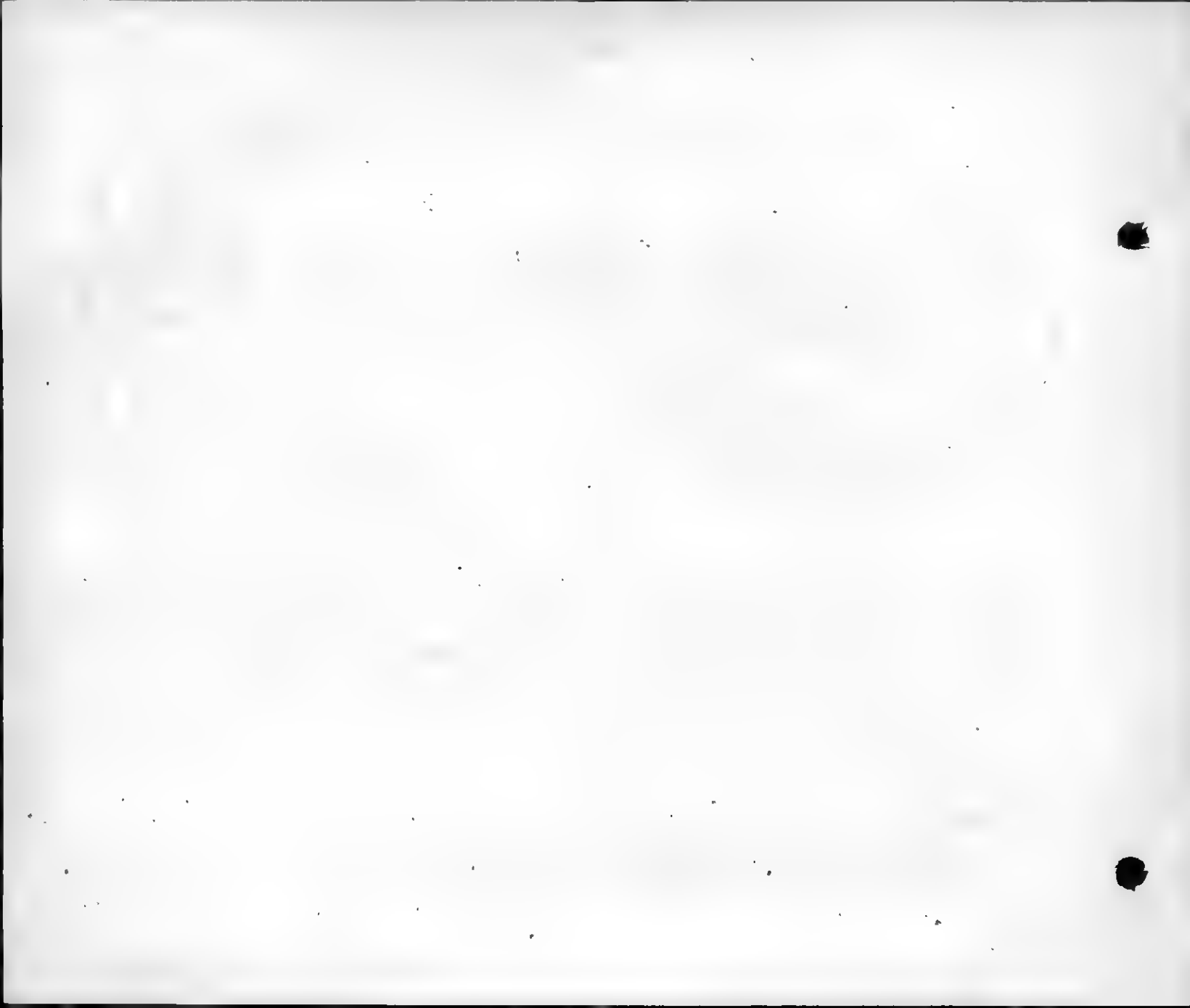
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS MS (4)
15M/5/58
None

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
8239									
CERTIFICATE OF DEATH									
Reg. Dist. No. 08172									
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>					c. LENGTH OF STAY IN 1b <u>1</u> <u>SILVER SPRING</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>2310 KANSAS AVE</u>				
3 NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GIRL</u> Last <u>JOHNSON</u>					4. DATE OF DEATH Month <u>JULY</u> Day <u>5</u> Year <u>19 60</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 5 1960</u>		9. AGE (In years last birthday) <u>—</u> yrs. <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PAUL JOHNSON</u>					14. MOTHER'S MAIDEN NAME <u>DOROTHY ELIZABETH REDDIX</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>			16. SOCIAL SECURITY NO <u>—</u>		INFORMANT <u>MOTHER</u>		Address <u>—</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> DUE TO <u>Immaturity</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost <u>Prematurity</u> DUE TO (b) <u>—</u> DUE TO (c) <u>—</u>									INTERVAL BETWEEN ONSET AND DEATH <u>1hr</u> <u>1hr</u> <u>1hr</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <u>—</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>						
20c. TIME OF INJURY Month. Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>JULY 5, 1960</u> to <u>JULY 5, 1960</u> , that I last saw the deceased alive on <u>JULY 5, 1960</u> , and that death occurred at <u>4:25 AM</u> , from the causes and on the date stated above									
ACTUAL SIGNATURE <u>Francis J Troendle</u> M.D.					ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd Rockville Md</u>				
PHYSICIAN'S NAME (Type) <u>Francis J. Troendle</u>					809 Viers Mill Road Rockville, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>		22b. DATE THEREOF <u>7-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Shaw O'Neale world Bethesda Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suburban Hospital 8600 OB Bayloun mory</u>					ADDRESS <u>Bethesda</u>		24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>
DATE <u>JUL 12 '60</u>					24c. REGISTRAR'S SIGNATURE <u>—</u>				

2074 285 XV0



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8182

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08173

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN 1b <u>1/2 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Southlawn Lane</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>Avery Rd</u>			
3. NAME OF DECEASED (Type of print) <u>Florence Johnson</u> First Middle Last				4. DATE OF DEATH <u>July 31 1960</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10, 1888</u> Month Day Year	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		9. AGE (in years, less birthday) <u>72</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M.n.	
13. FATHER'S NAME <u>Augustus Williams</u>				14. MOTHER'S MAIDEN NAME <u>Ida Botts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Lorenzo Johnson</u> Address <u>Southlawn Lane Rockville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>hypertension</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a); INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>?</u>							
2da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				2db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
2dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		2dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		2de. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL EXAMINER'S NAME (Type) <u>Frank J. Broschalt</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>7-31-60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-4-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant</u>		22d. LOCATION (City, town, or county) (State) <u>Narbeck, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MEDICAL CERTIFICATE

Proprietor William B. Ball
- owner of general

South Lane
No. 1, 11th St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8240

CERTIFICATE OF DEATH

08174

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #1 Germantown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD #1 Germantown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Maurice O. Johnson, Sr.			4. DATE OF DEATH July 14 1960		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 10, 1911	9. AGE (In years last birthday) 49 yrs	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Same		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles W. Johnson			
14. MOTHER'S MAIDEN NAME Nettie L. Hungerford		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. 21214 1711		INFORMANT Dorothy Repp Address Rt. #2 Union Bridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 hours					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 7/16/60 to 7/14 , 19 60 that I last saw the deceased alive on 7/16/60 , 19 60 , and that death occurred at M , from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Kerr M.D.		ADDRESS (Street, city or town, state) Damascus, Md		DATE SIGNED 7/19/60	
PHYSICIAN'S NAME (Type) Dr. James P. Kerr		Damascus, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-16-60	22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		22d. LOCATION (City, town, or county) (State) Cedar Grove, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber ADDRESS Laytonville, Md.		24a. REC'D BY REGISTRAR JUL 19 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kraus	



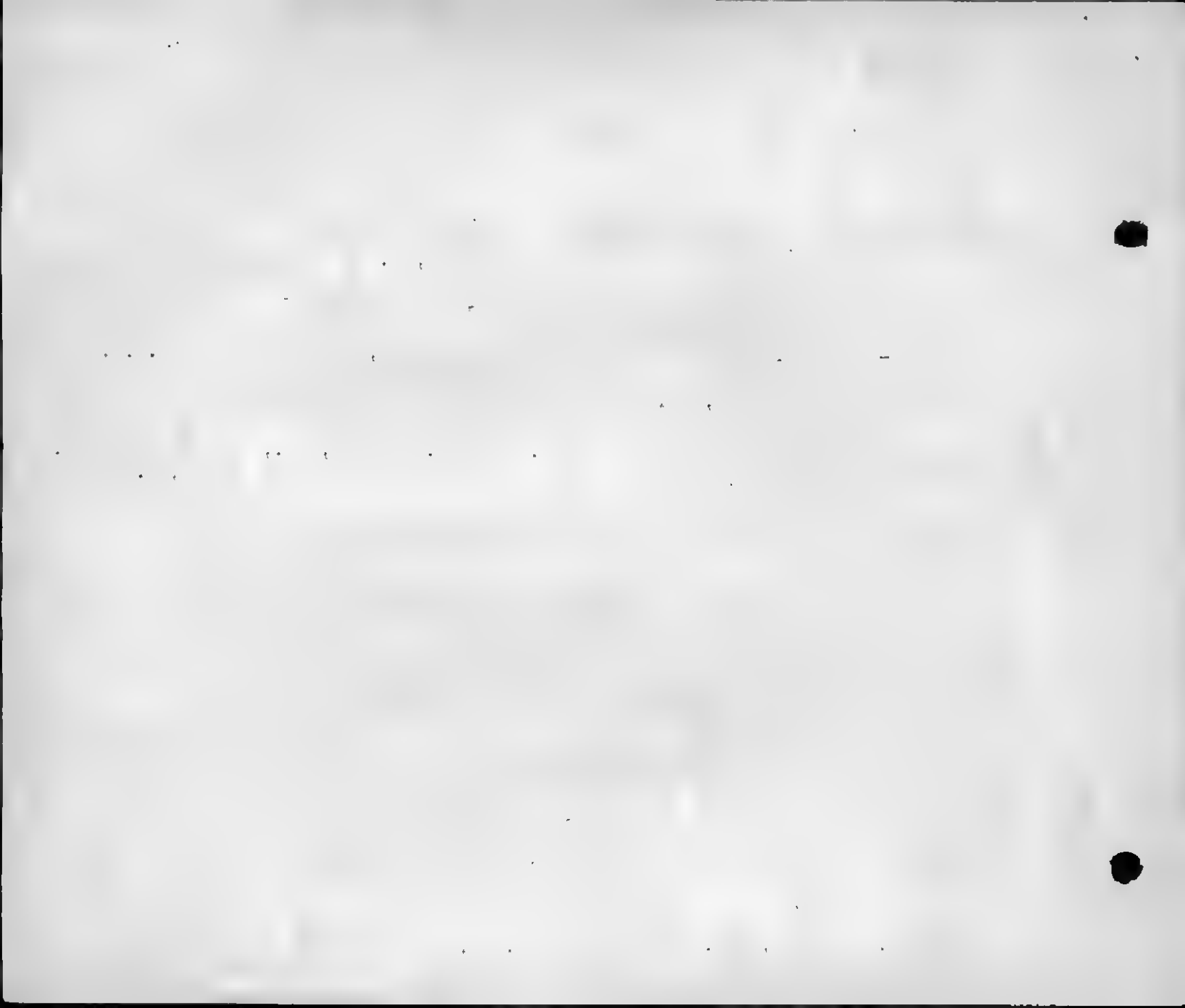
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

1
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8118 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08175

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN IL <u>1</u>		d. STREET ADDRESS <u>3310 Randolph Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Woodburn Farm - Layhill Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN William</u>		4. DATE OF DEATH <u>July 18 1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>7-18-1945</u>	
9. AGE (in years) <u>15</u> yrs		10. IF UNDER 1 YEAR: Months <u>15</u> Days <u>15</u>	
11. BIRTHPLACE (State or foreign country) <u>Williamsport, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John William Johnson, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Marion Annabelle Orso</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. John Wm. Johnson, Sr., 3310 Randolph Rd. Silver Spring, MD</u>		Address <u>Silver Spring, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>drowning</u> DUE TO (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: <u>none</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned in pond while swimming</u>	
20c. TIME OF INJURY Month, Day, Year <u>7-18 1960</u>		20d. INJURY OCCURRED <u>While at work</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Silver Spring</u> (County) <u>Montg</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschack</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschack</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/21/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. BUMPSTEAD, INC.</u>		24a. REC'D BY REGISTRAR <u>JUL 22 '60</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, and in any event within 72 hours after death.

Medical Examiner notified and approved

81119

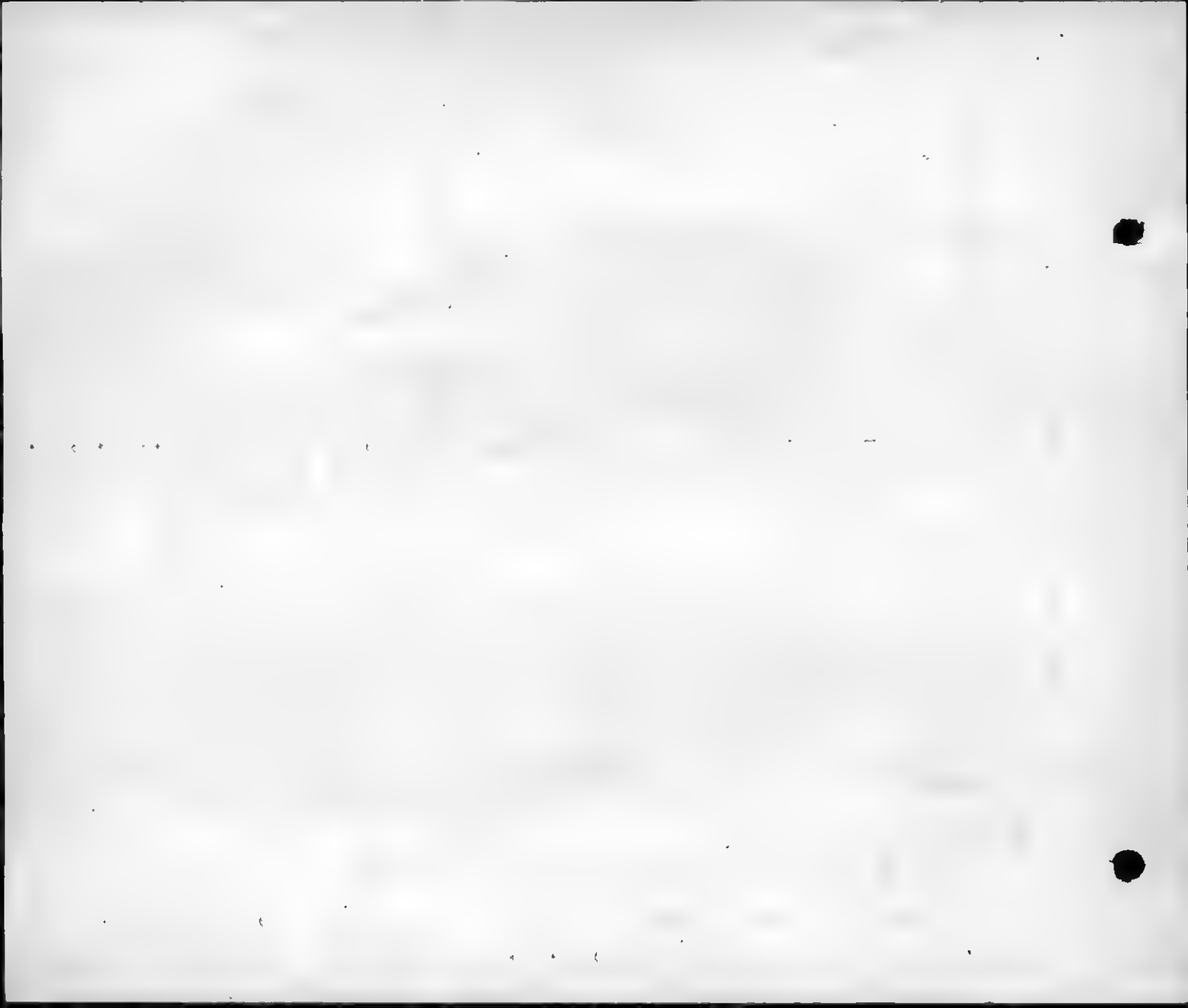
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 16 MilmG 208 8-8-60 et

08176

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4510 Mahan Road		d. STREET ADDRESS 4510 Mahan Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALEXANDER Middle KALASSAY Last KALASSAY		4. DATE OF DEATH July 29 1960 Month July Day 29 Year 1960	
5 SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1896
9 AGE (In years last birthday) 64 yrs		IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Kalassay Alexander Kalassay		14. MOTHER'S MAIDEN NAME Elizabeth Abatazy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service) 578-3J-5952	
17. INFORMANT Getha Kalassay, 4510 Mahan Rd., S.S., Md.		Address 	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A.C. Coronary Thrombosis DUE TO 420-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease DUE TO Generalized Atherosclerosis (c) 		INTERVAL BETWEEN ONSET AND DEATH 14 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 1950 to July 27, 1960 , that (I) (we) last saw the deceased alive on July 6, 1960 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Bernard Katzen M.D.		22b. DATE SIGNED 7-29-60	
22c. PHYSICIAN'S NAME (Type) BERNARD KATZEN M.D. 3555 MICHIGAN AVE. S.W. Wash, D.C.		22d. ADDRESS 	
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE THEREOF 7/30/1960	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	23d. LOCATION (City, town, or county) (State) Suitland, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Bauer's Sons		25a. REC'D BY REGISTRAR DATE AUG 2 '60	
ADDRESS Washington, D. C.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 12 hours after death.

VS. A15ME
5M 7/59

158177
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8241
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8600 Brickyard Rd</u>		d. STREET ADDRESS <u>8600 Brickyard Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Paul Jay Kasloff</u>	4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1960</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1914</u> <u>43</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NY</u>	
11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Kasloff</u>		14. MOTHER'S MAIDEN NAME <u>Rose</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1-20-1</u>	
17. INFORMANT <u>Mary Kasloff - Sister</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>Frank J. Broschalt</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschalt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden</u>		22d. LOCATION (City, town, or country) (State) <u>Falls Church, Virginia</u>	
23. FUNERAL DIRECTOR <u>B. Danzansky & Sons</u>		ADDRESS <u>W 354, D.C.</u>	
24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

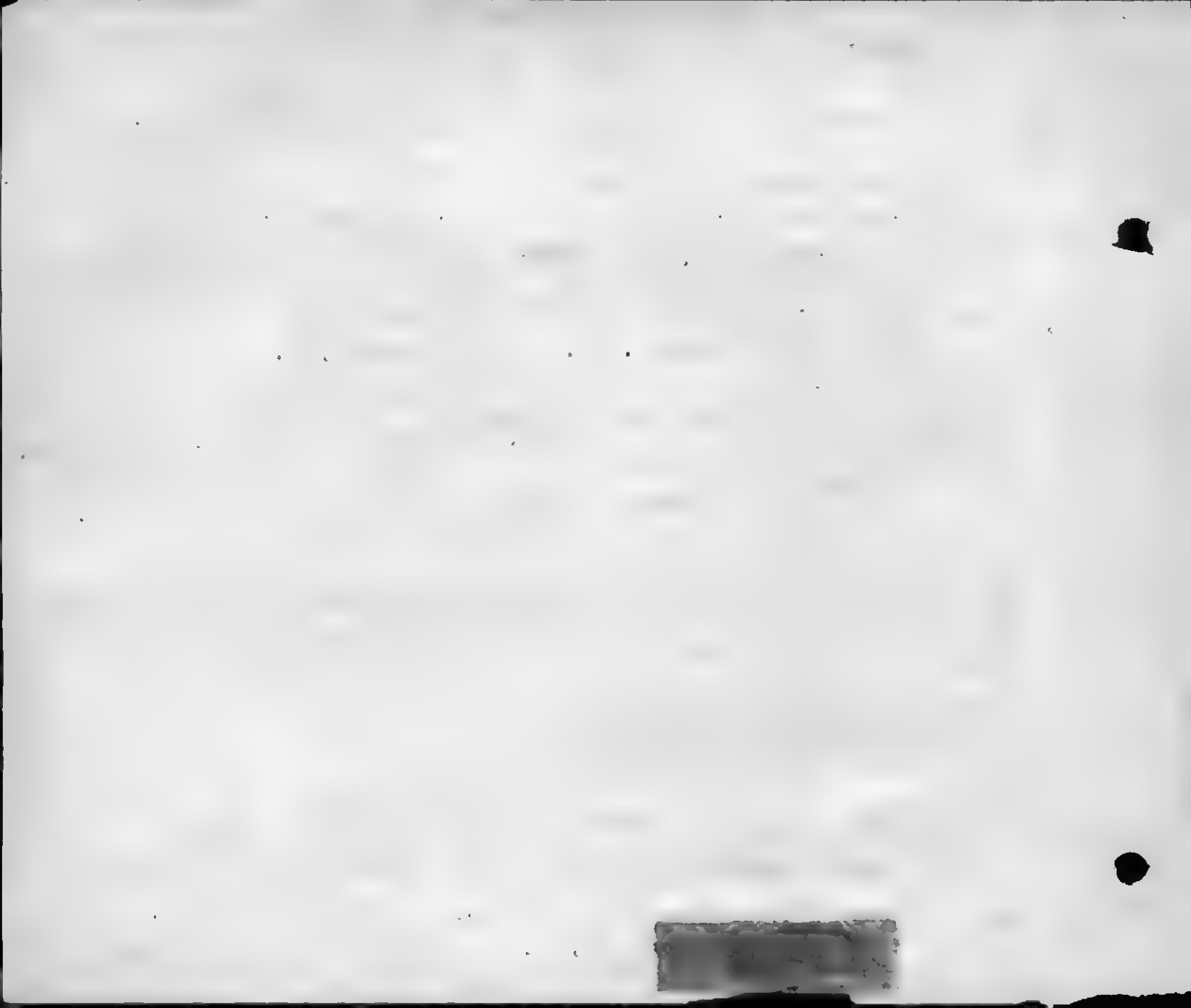
VS. A15ME
5M 7/59

8183 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08178

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN b. MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 220 N. Washington St.		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 220 N. Washington St.	
3. NAME OF DECEASED (Type or print) Charles D. Kelly		4. DATE OF DEATH July 11, 1960	
5. SEX male	6. COLOR OR RACE col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10/1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Charlottesville, Va.	
13. FATHER'S NAME Richard Kelly		14. MOTHER'S MAIDEN NAME Emma E. Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) World War # 2		16. SOCIAL SECURITY NO. ?	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Found dead in bed. DUE TO (c)		17. INFORMANT Mrs. Emma Hollins Address 807 West St., Charlottesville, Va.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 13, 1960	
22c. NAME OF CEMETERY OR CREMATORY Oakwood cemetery.		22d. LOCATION (City, town, or country) (State) Charlottesville, Va.	
23. FUNERAL DIRECTOR Robert L. Sullivan ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR JUL 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

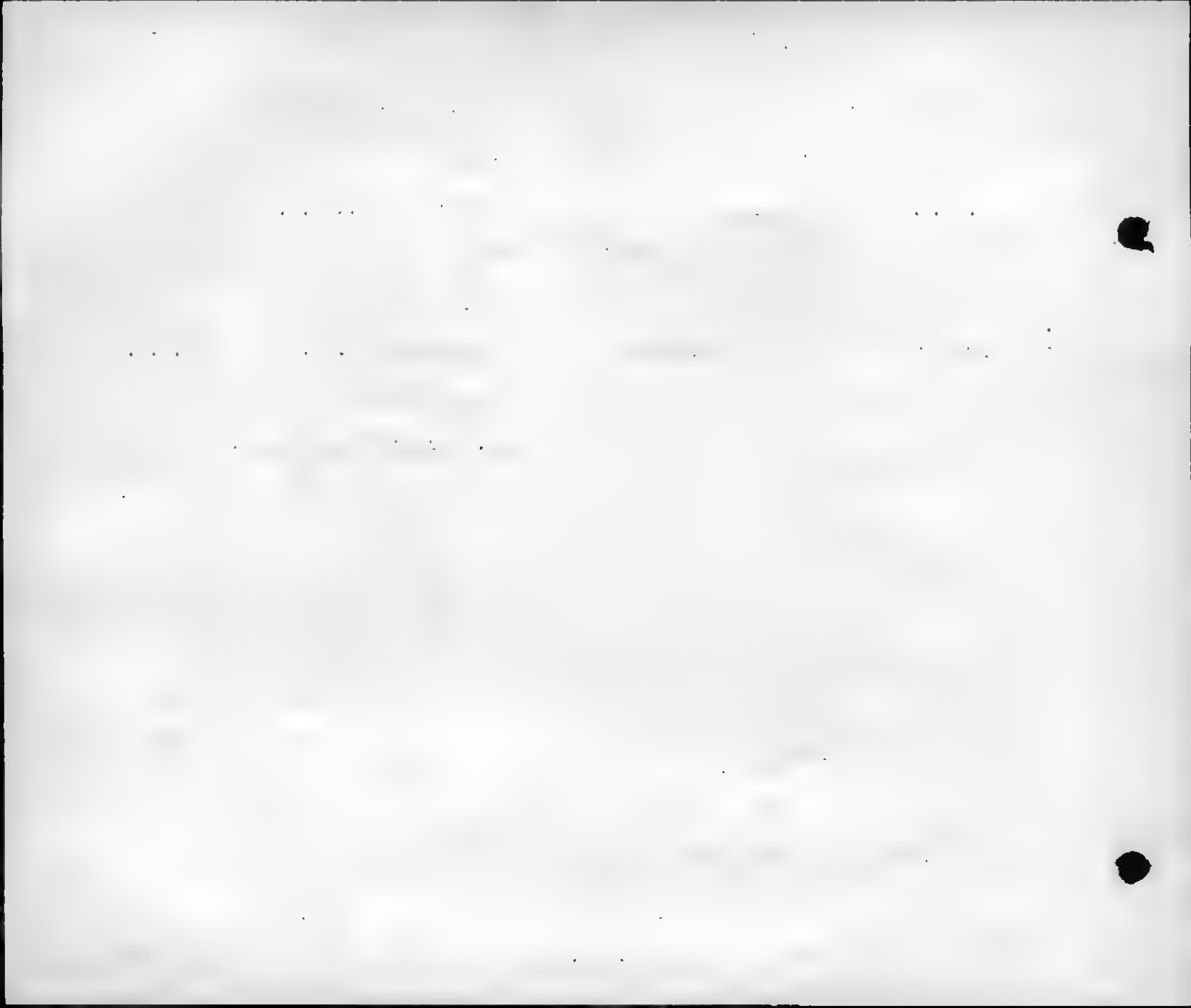
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15M 9/59

8242

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08179

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
f. STREET ADDRESS 739 Irving St., N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last KELSON		4. DATE OF DEATH Month July Day 4 Year 1960	
5. SEX Male	6. COLOR OR RACE Negroid	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-84
9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 75 Days 75 Hours 75 Min 75	11. IF UNDER 24 HRS Months 75 Days 75 Hours 75 Min 75	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver		10b. KIND OF BUSINESS OR INDUSTRY Taxi Cab	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James KELSON		14. MOTHER'S MAIDEN NAME Sarah BARBARA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (W) Mrs. Margaret Key Kelson, same as #2 above	
17. INFORMANT (W) Mrs. Margaret Key Kelson, same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 18 days 3 yrs 10 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. June 15 1960 p. m. July 4 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 15 1960 to July 4 1960 , that (I) (we) last saw the deceased alive on July 4 1960 , and that death occurred at 7-4-60 M, from the causes and on the date stated above.		22a. SIGNATURE John Wood Davis	
22b. PHYSICIAN'S NAME (Type) JOHN WOOD DAVIS LT MC USN		22c. ADDRESS 7-4-60	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-8-60	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE McGuire Funeral Home		25a. REC'D BY REGISTRAR DATE JUL 6 '60	
ADDRESS McGuire Funeral Home, 1820 9th St., NW, WashDC		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

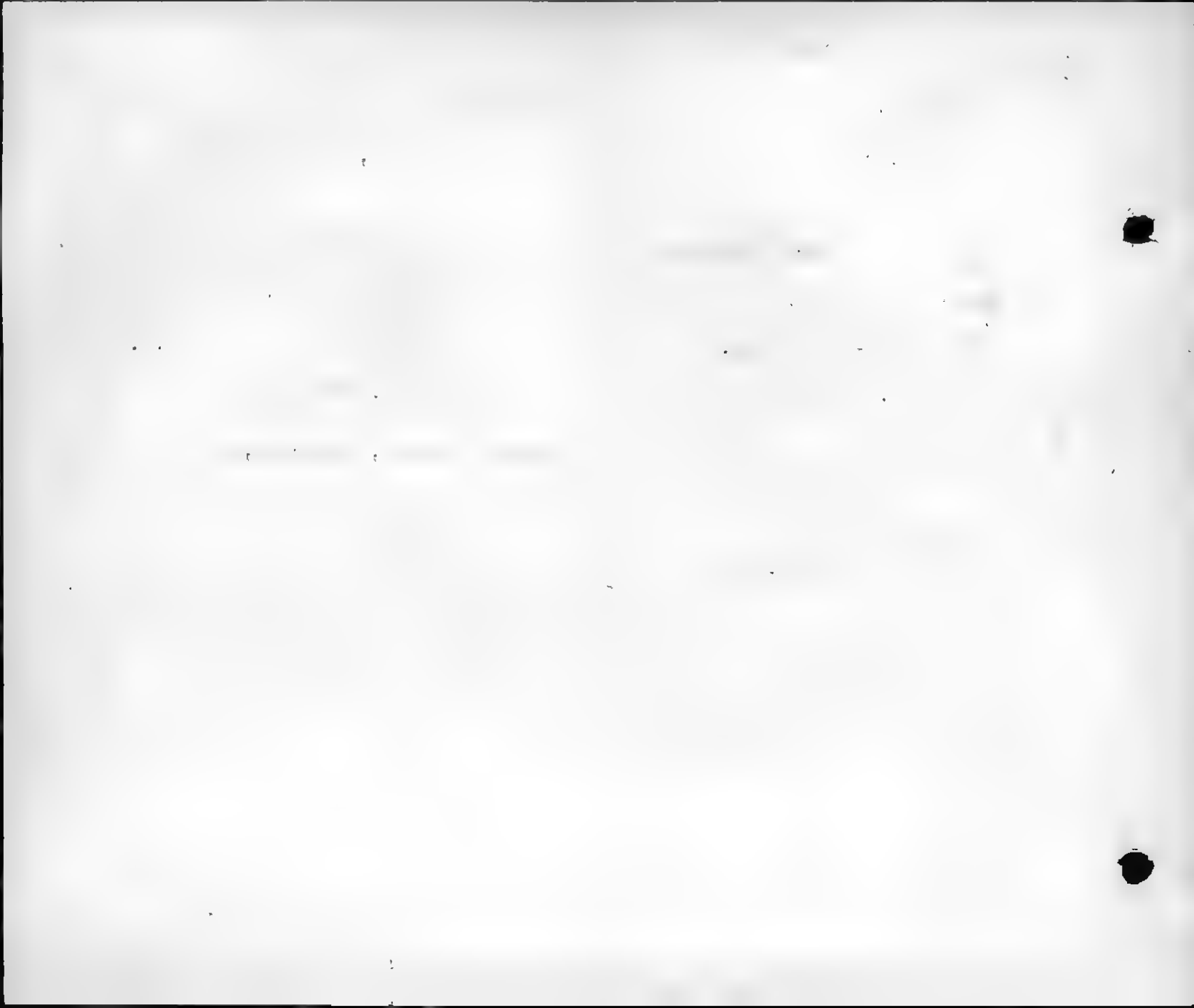


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8243
Item 1 Bill 6247 7-26-60 et
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 08180

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dickerson		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Montgomery	
c. LENGTH OF STAY IN lb 1 yr		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barnesville, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Private Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mary Middle Rebecca Last Kessler		4. DATE OF DEATH Month July Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 4-1889
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife-----own home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Henry L. Clements		14. MOTHER'S MAIDEN NAME Nellie M. Nicholson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Thomas Kessler, Dickerson, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Cerebral Arteriosclerosis DUE TO (c) Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 days 1 year 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3, 1960 to July 8, 1960 that I last saw the deceased alive on July 7, 1960 and that death occurred at 8:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Vernon E. Martens M.D.		ADDRESS (Street, city or town, state) Barnesville, Md DATE SIGNED July 8-60	
PHYSICIAN'S NAME (Type) Vernon E. Martens			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/11/70	22c. NAME OF CEMETERY OR CREMATORY St Marys	22d. LOCATION (City, town, or county) (State) Barnesville, Md
23. FUNERAL DIRECTOR'S SIGNATURE Constance C. Hilton ADDRESS Barnesville, Md		24a. REC'D BY REGISTRAR DATE JUL 13 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

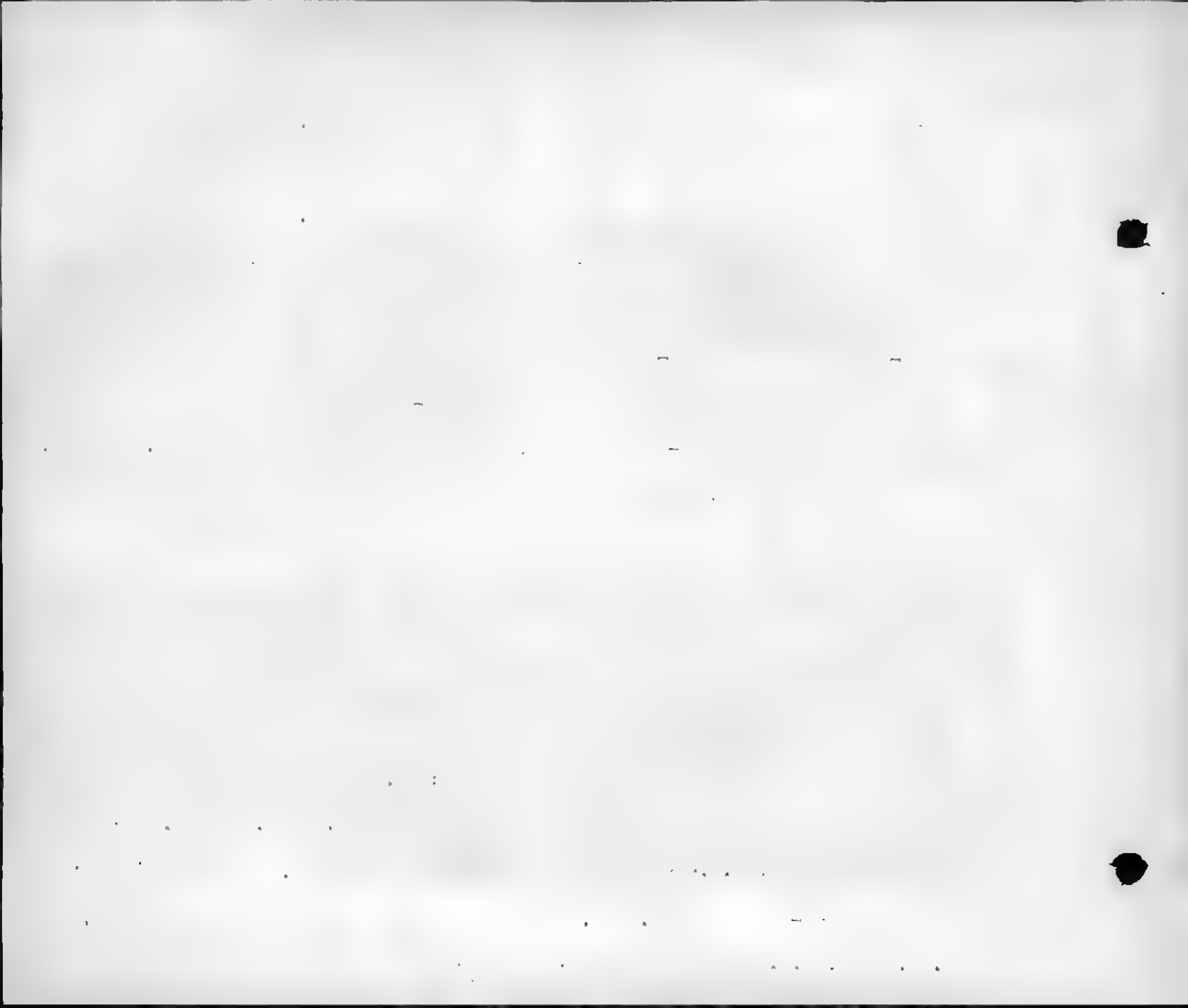
8142

CERTIFICATE OF DEATH

Reg. Dist. No.

118181

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park				c. LENGTH OF STAY IN 1b 7 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Sanitarium & Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 17 Takoma Park			
f. STREET ADDRESS 900 Kennebec Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Linda Hyun-Sook Kim				4. DATE OF DEATH Month Day Year July 28 19 60			
5. SEX Female		6. COLOR OR RACE Brown		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 21, 1960	
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Gun Hyuk Kim				14. MOTHER'S MAIDEN NAME Kung-Hie Lyu			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Mrs. Gun Hyuk Kim				Address 900 Kennebec Ave., TP, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 21 , 19 60 , to July 28 , 19 60 , that I last saw the deceased alive on July 28 , 19 60 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 7600 Carroll Ave., Tak. Pk, Md. 8-7-60							
ACTUAL SIGNATURE Emma Hughes M.D. 7600 Carroll Ave., Tak. Pk, Md. 8-7-60							
PHYSICIAN'S NAME (Type) Emma Hughes, M.D., 7600 Carroll Ave., Takoma Park, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 8-2-60		22c. NAME OF CEMETERY OR CREMATORY Wash. San. & Hospital		22d. LOCATION (City, town, or county) (State) Takoma Park Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robt. A. Hare, M.D. 7600 Carroll Ave., TP, Md.				24a. REM. BY REGISTRAR 10 60			
24b. REGISTRAR'S SIGNATURE 2075 301XV1							



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
FURNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

(M)

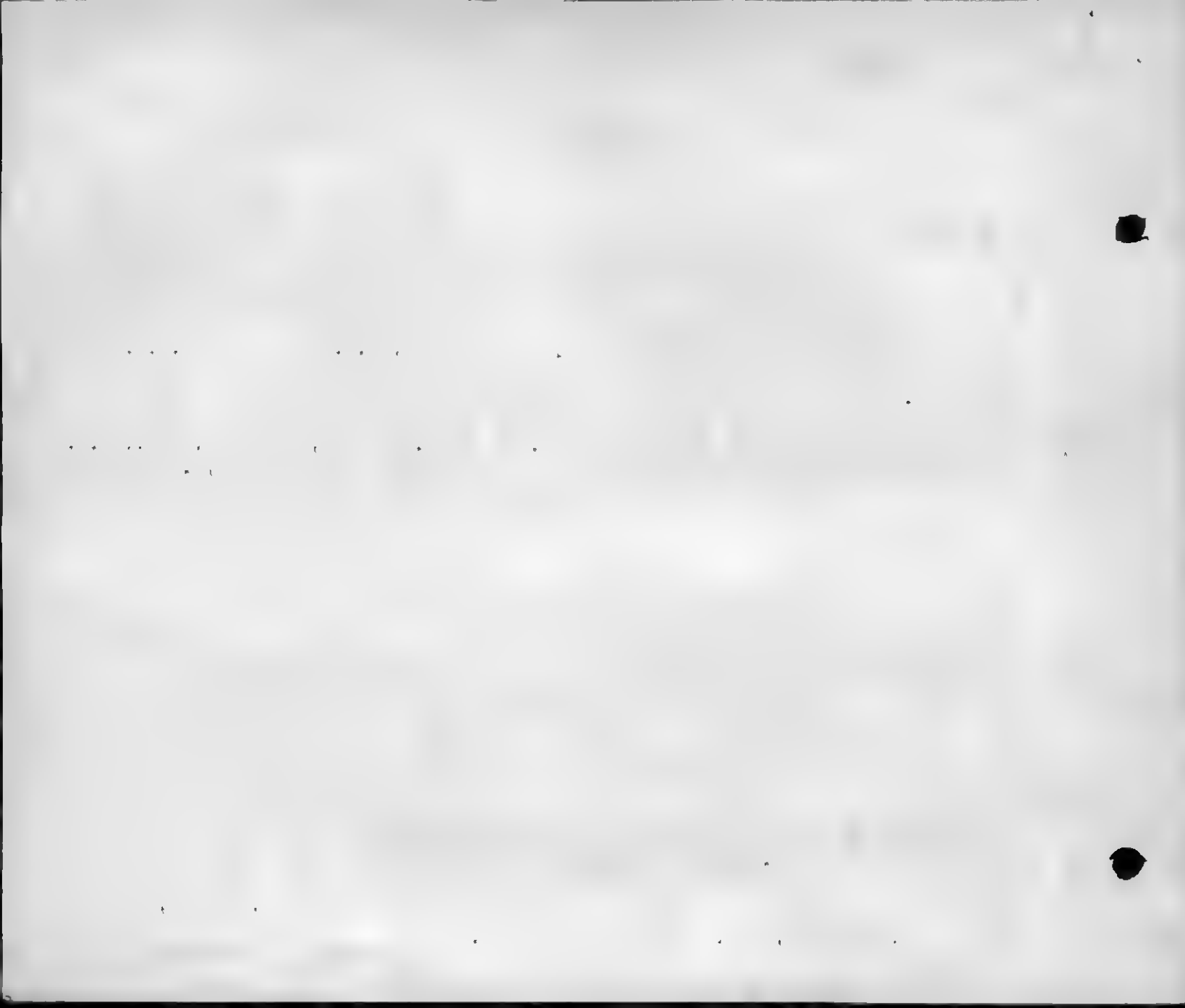
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8143

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08182

1. PLACE OF DEATH a. COUNTY MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK			
c. LENGTH OF STAY IN 1b 3 months				d. STREET ADDRESS 7700 TAKOMA AVENUE			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7700 TAKOMA AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEONARD		First Middle Last MARION KING		4. DATE OF DEATH Month Day Year JULY 24 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 11/8/13	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installed awnings		10b. KIND OF BUSINESS OR INDUSTRY Awnings		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME George T. King				14. MOTHER'S MAIDEN NAME Susan Clementson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW #2				16. SOCIAL SECURITY NO. yes			
17. INFORMANT Mrs. Martha M. Johnson, 4501 Ill. Ave., N.W. Washington, D.C.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 min DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 7/27/60			
22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY				22d. LOCATION (City, town, or country) (State) PRINCE GEO. COUNTY, MARYLAND			
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC.				24a. REC'D BY REGISTRAR DATE JUL 28 '60			
ADDRESS SILVER SPRING, MD.				24b. REGISTRAR'S SIGNATURE Arthur S. Klaus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8120

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08183

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>134 RITCHIE AVE.</u>		d. STREET ADDRESS <u>134 RITCHIE</u>	
3. NAME OF DECEASED (Type or print) First <u>RUTH</u> Middle <u>JEAN</u> Last <u>KLIMASZEWSKI</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>27</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 29, 1927</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANK CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANK</u>	
11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLINTON SAYRE</u>		14. MOTHER'S MAIDEN NAME <u>JULIA WEAVER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>EDWARD KLIMASZEWSKI</u>		Address <u>134 RITCHIE AVE. SILVER SPRING MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Air Embolism</u>			
DUE TO <u>Entry of air into venous circulation thru</u>			
uterine wall from partially separated placenta.			
Cause: to be determined. (deceased pregnant with			
twins, about 12 to 13 weeks gestation)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>AUGUST 1, 1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>DALLAS, LUTERNE CO., PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>254 CARROLL ST. N.W. WASHINGTON D.C.</u>		24. REC'D BY REGISTRAR <u>DATE AUG 1 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

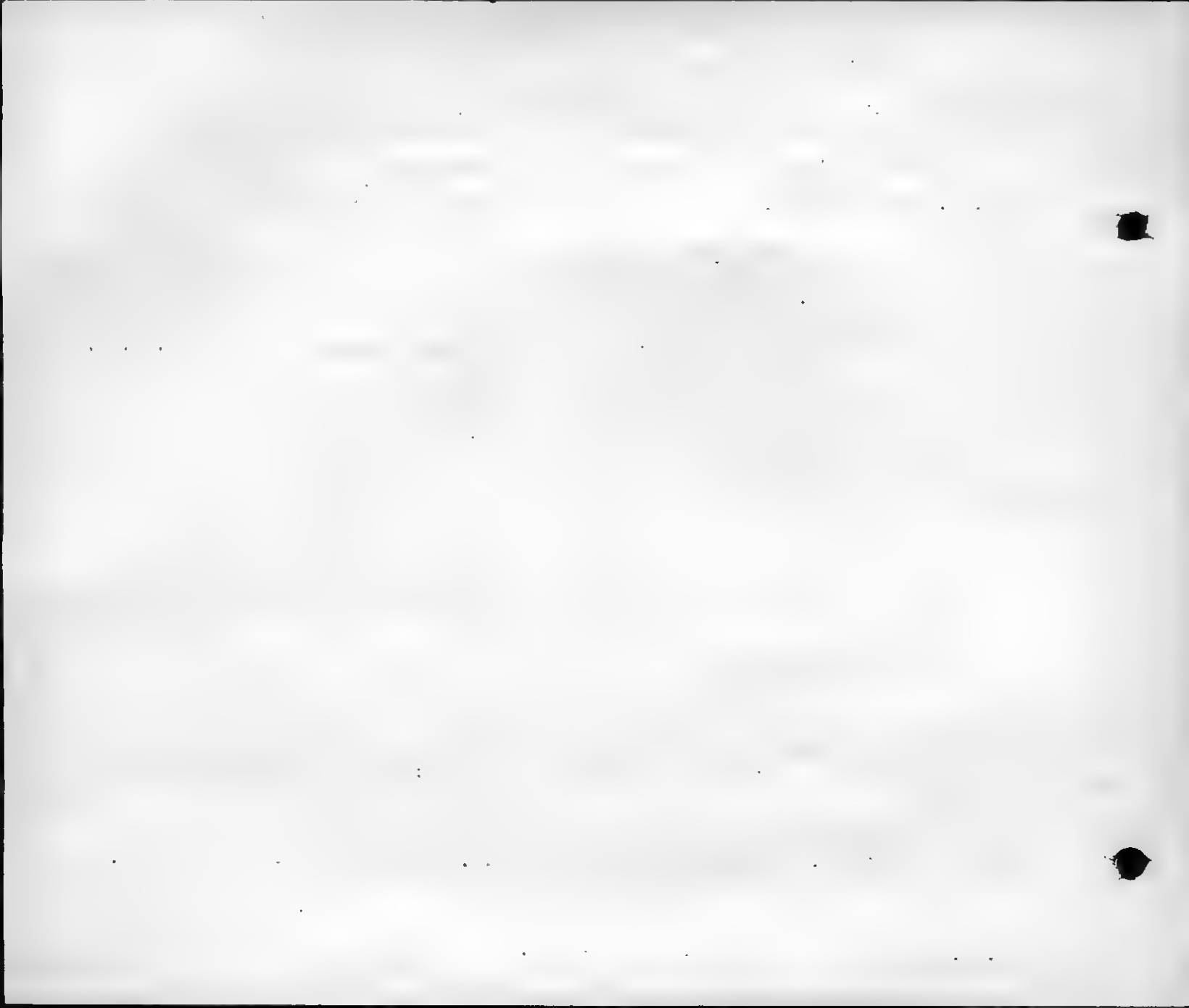
8244

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08184

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> c. LENGTH OF STAY IN 1b <u>6 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Naval Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u> d. STREET ADDRESS <u>Trailer Camp Rt#1 Box 17D Bryans Road</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>XXXXXXXXXX</u> <u>Joseph</u> <u>KNAPP</u>		4. DATE OF DEATH Month Day Year <u>July</u> <u>23</u> <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 22, 1960</u>
9. AGE (In years last birthday) yrs <u>8</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Dallas Leslie KNAPP</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Louise HAMMOND</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Father</u> Address <u>(See #2 Above)</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>762.5</u> IMMEDIATE CAUSE (a) <u>Neonatal Atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>762.5</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 22</u> <u>1960</u> , to <u>23 July</u> <u>1960</u> , that (I) <u>was</u> last saw the deceased alive on <u>July 23</u> <u>1960</u> , and that death occurred at <u>2:30 AM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Fred W. Grello</u> 22c. PHYSICIAN'S NAME (Type) <u>Fred W. GRELLO LT MC USN</u>		22b. DATE SIGNED <u>7-23-60</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-26-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Pumphrey</u> ADDRESS <u>R. A. Pumphrey Funeral Home, Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE JUL 28 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>

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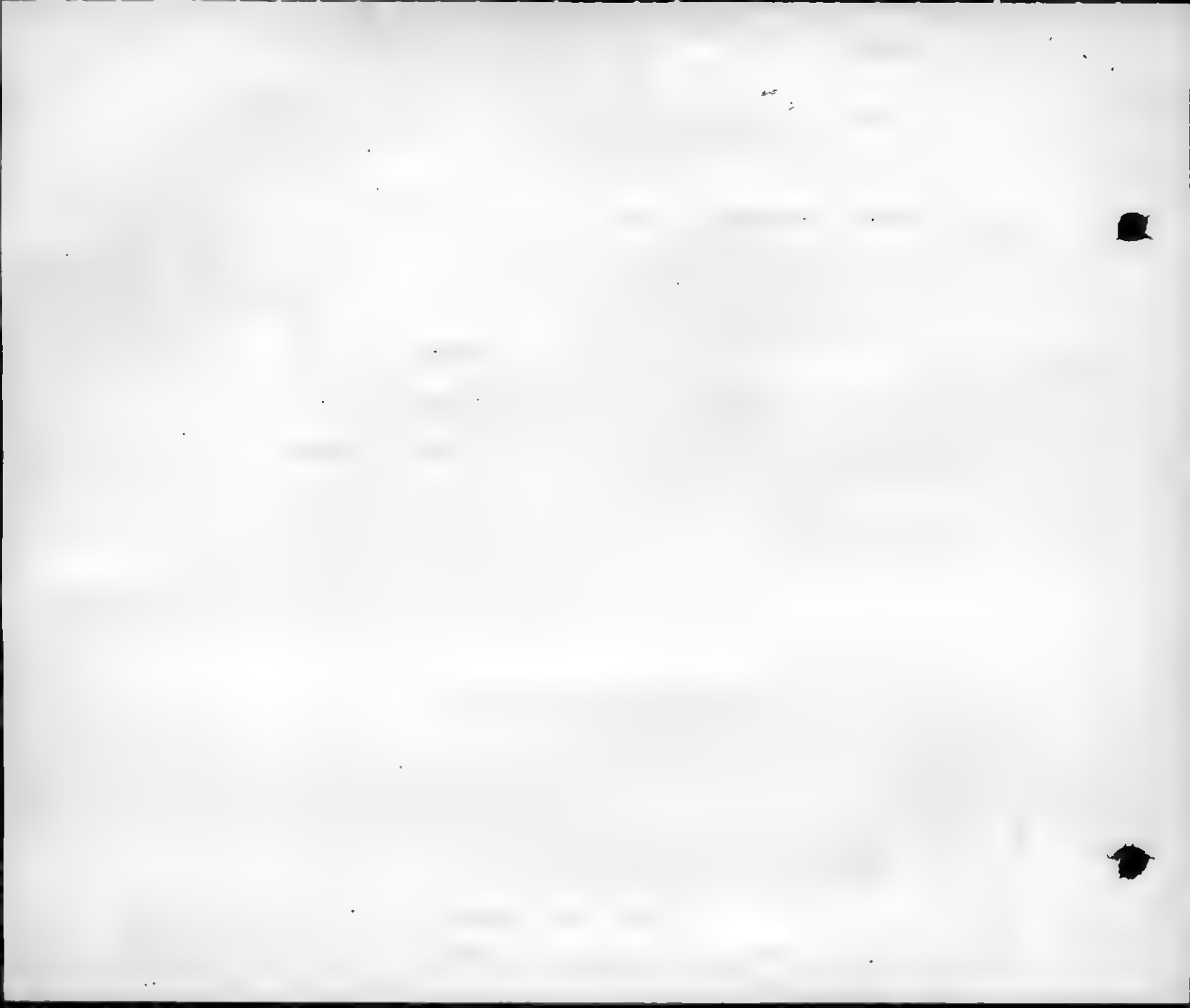


1
8144
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08185

1. PLACE OF DEATH a. COUNTY <u>Montgomery Md.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>mont.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lakoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 CHEVY CHASE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Jan & Hosp</u>				d. STREET ADDRESS <u>14411 Elm St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>CHARLES</u> Middle <u>KRACEK</u> Last				4. DATE OF DEATH Month <u>7</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-90</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>19</u> Min <u>60</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>5</u> Hours <u>19</u> Min <u>60</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Physicist</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>	
13. FATHER'S NAME <u>MATTHEW KRACEK</u>				14. MOTHER'S MAIDEN NAME <u>MARY MARCHAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>p.t. Hosp record.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastatic Carcinoma</u> (c) <u>Carcinoma of the Lung</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>24.62</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1960</u> to <u>July 5, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1960</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7/5/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>				22d. ADDRESS <u>7600 Carroll Ave T.H.K. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>7/8/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				25a. REC'D BY REGISTRAR <u>JUL 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8121

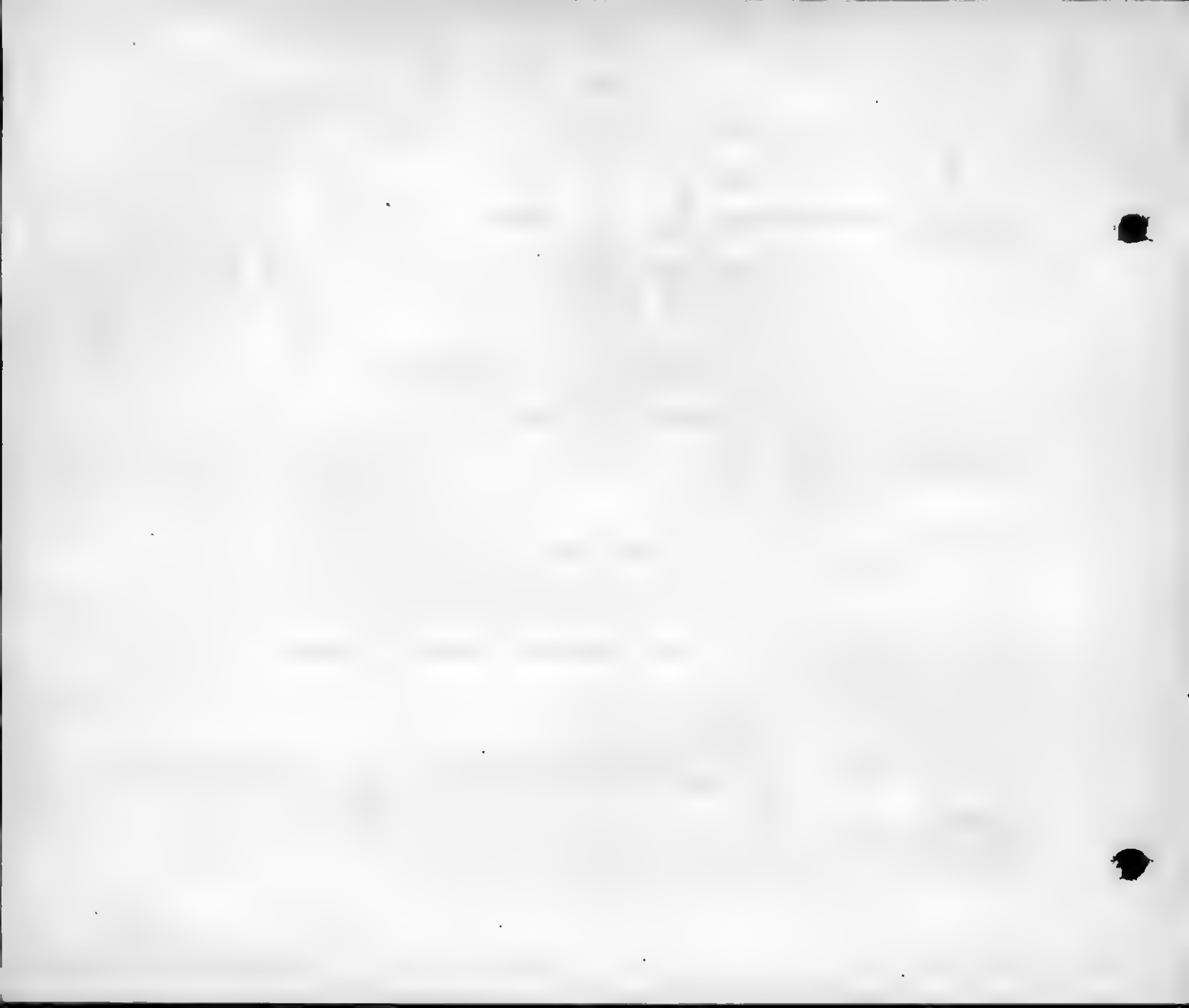
CERTIFICATE OF DEATH

08186

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9201 Coleville Road</i>		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> d. STREET ADDRESS <i>9201 Coleville Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>OLIVE</i> Middle <i>BLANCHE</i> Last <i>KREUZBURG</i>		4. DATE OF DEATH Month <i>July</i> Day <i>13</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 1, 1877</i>
9. AGE (In years last birthday) <i>82</i> yn.		10. IF UNDER 1 YEAR: Months <i>8</i> Days <i>13</i> Hours <i>13</i> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant Owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food</i>	
11. BIRTHPLACE (State or foreign country) <i>Cincinnati, Ohio</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Will Morgan</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Richard J. Kreuzburg</i>		Address <i>3713 Cardy Rd. Chch.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Heart Disease</i> (c) <i>arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i> <i>5 years</i> <i>10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1952</i> to <i>July 13, 1960</i> , that I last saw the deceased alive on <i>July 12, 1960</i> , and that death occurred at <i>4 A.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>Manuel Foret M.D.</i>		ADDRESS (Street, city or town, state) <i>1746 K St N.W.</i> DATE SIGNED <i>7/13/60</i>	
PHYSICIAN'S NAME (Type) <i>MARCEL J. FORET</i>			
22a. BURIAL, CREMATION, or other disposal (Specify) <i>Burial</i>		22b. DATE THEREOF <i>July 18, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Spring Grove Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Cincinnati, Ohio</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Richard Walters</i>		ADDRESS <i>254 Carroll St NW DC</i>	
24a. REC'D BY REGISTRAR <i>JUL 18 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Knecht</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



8245

CERTIFICATE OF DEATH

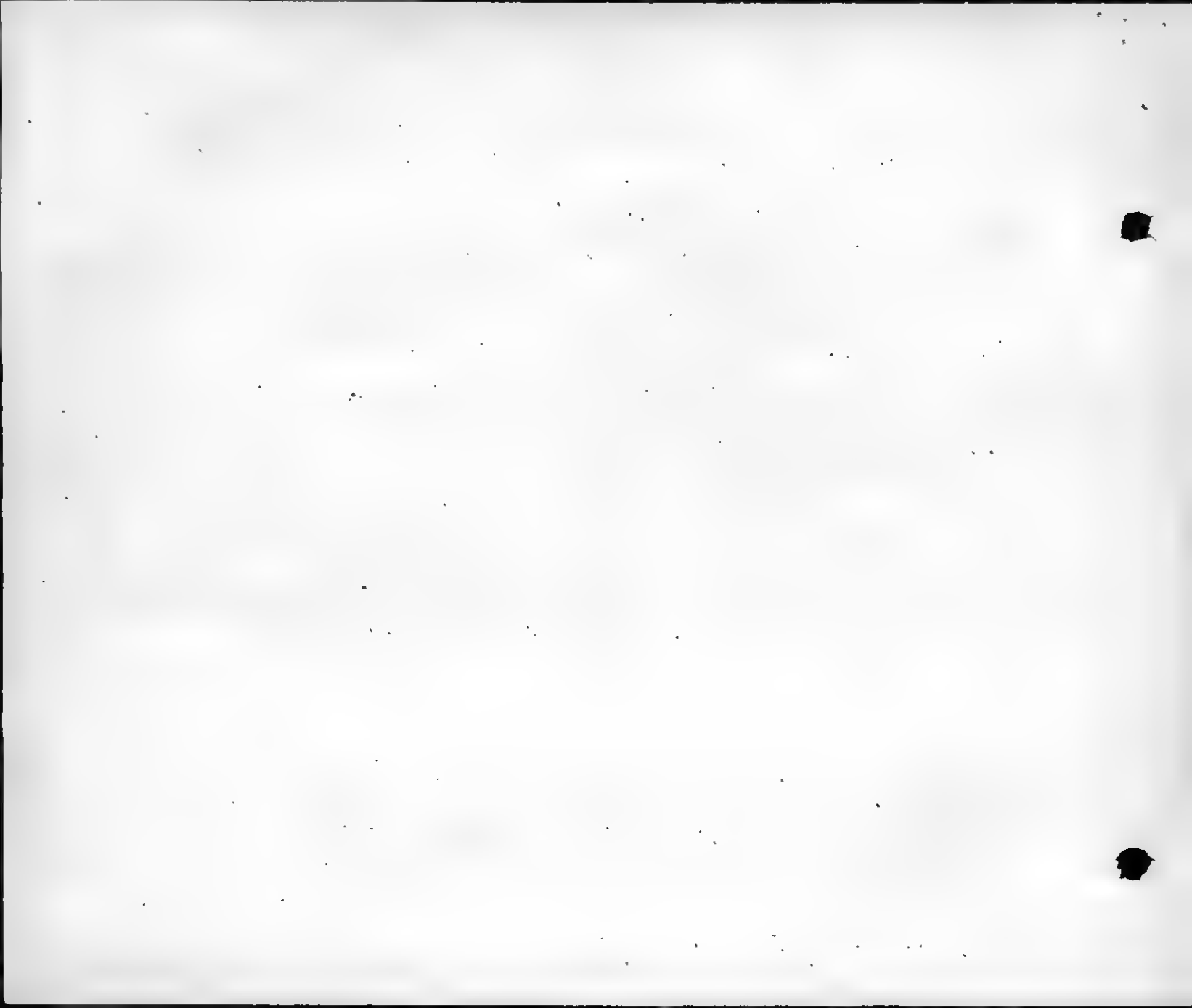
Reg. Dist. No.

08186

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>1702 Willoughby St. Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. STREET ADDRESS <u>1702 Willoughby St. Rockville</u>	
3. NAME OF DECEASED (Type or print) <u>Edward Zephier</u> First Middle Last <u>LABRIE</u>		4. DATE OF DEATH <u>July 1</u> Month Day Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-30-88</u>
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Circulation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>News paper.</u>	
11. BIRTHPLACE (State or foreign country) <u>So Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur LaBrie</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Victoria LeFort</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>48605-4407</u>	
17. INFORMANT <u>Rockville</u>		Address <u>702 W. Willoughby</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u>			<u>24 hrs</u>
DUE TO <u>Pulmonary Emphysema</u>			<u>3 yrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary Fibrosis</u>			<u>Indefinite</u>
DUE TO (c) <u>Congestive Heart Failure</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/2, 1959</u> to <u>7/1/1960</u> that I last saw the deceased alive on <u>7/1/1960</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen N. Jones</u>		ADDRESS (Street, city or town, state) <u>Rockville, Md</u> DATE SIGNED <u>7/1/60</u>	
PHYSICIAN'S NAME (Type) <u>Stephen N. Jones</u>		<u>Rockville, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Kansas City, Kansas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Montgomery Avenue Rockville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8122

CERTIFICATE OF DEATH

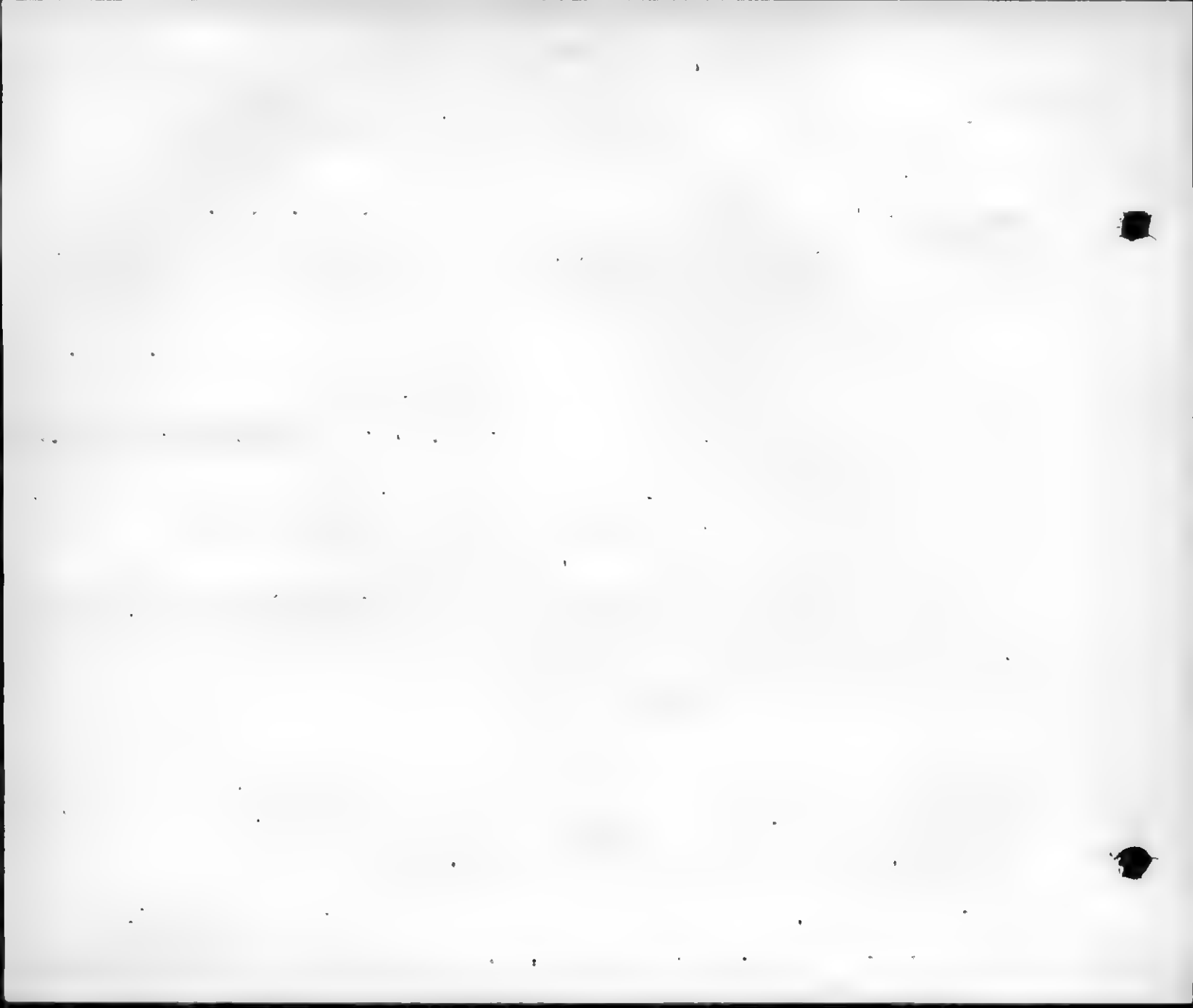
08183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Kennedy-Warren b. COUNTY Washington D. C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Md.				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Althea Woodland N.H.				d. STREET ADDRESS 3133 Conn. Ave. N. W.			
3. NAME OF DECEASED (Type or print) First Alice Middle F. Lanham Last F. Lanham				4. DATE OF DEATH Month July Day 24 Year 19 60			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17-1876	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 84 Days 84 Hours 84 Min 84	IF UNDER 24 HRS Months 84 Days 84 Hours 84 Min 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY D of C		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac Fearing				14. MOTHER'S MAIDEN NAME Henrietta Grandy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		INFORMANT Renah F. Camalier Address Washington, DC 5001 Van Ness St. NW			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO 1 week DUE TO 1 week PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma left breast (postoperative status)						INTERVAL BETWEEN ONSET AND DEATH 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 15, 1960 to July 24, 1960 , that I last saw the deceased alive on July 23, 1960 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W.K. Billingsley Jr. M.D.				DATE SIGNED 7-24-60			
PHYSICIAN'S NAME (Type) WILLIAM K. BILLINGSLEY JR. M.D.				ADDRESS (Street, city or town, state) 1835-6 St. N.W.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				24a. REC'D BY REGISTRAR JUL 26 '60		24b. REGISTRAR'S SIGNATURE C. L. S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed with the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

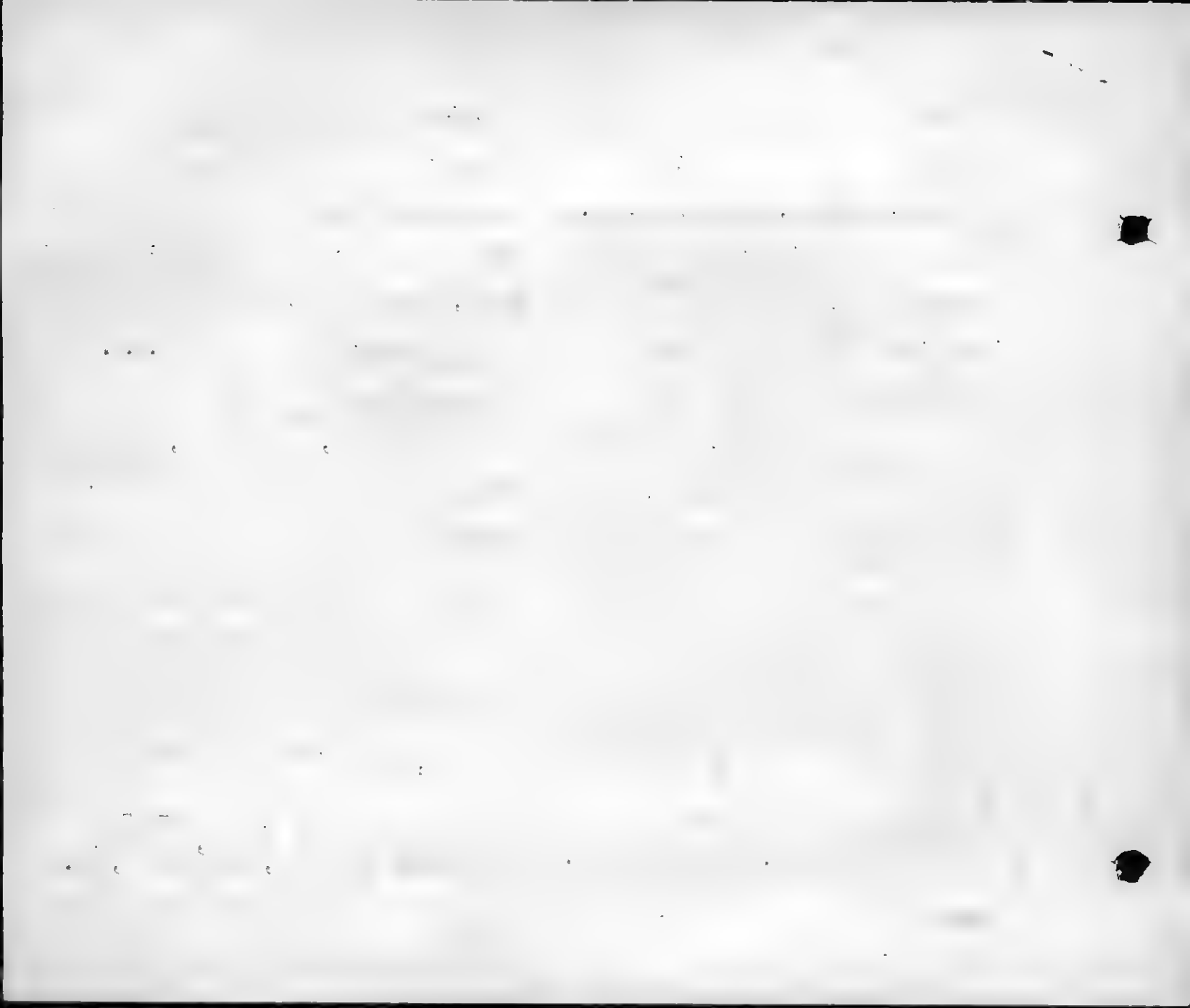
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15M 9/59

8246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08190

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New Jersey b. COUNTY Teaneck c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 362 Balsam Street d. STREET ADDRESS 362 Balsam Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Vivian (None) LaRose			4. DATE OF DEATH Month Day Year July 24 19 60		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 21, 1930		9. AGE (In years last birthday) 30 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		12. KIND OF BUSINESS OR INDUSTRY None		13. BIRTHPLACE (State or foreign country) New Jersey	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME Victor Ippolito		16. MOTHER'S MAIDEN NAME Marianni Zica	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO Unascertainable		19. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myelogenous Leukemia DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 Day 6 Months					
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
23. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		24. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
26. I certify that (I) (this hospital) attended the deceased from June 27 19 60 to July 24 19 60 , that (I) (we) last saw the deceased alive on July 24 19 60 , and that death occurred at 4:25 PM , from the causes and on the date stated above.					
27. SIGNATURE Richard E. Rieselbach, M.D. 28. PHYSICIAN'S NAME (Type) RICHARD E. RIESELBACH, M.D.		29. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 30. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		31. DATE SIGNED 7-25-60	
32. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 7-25-60		33. DATE THEREOF 7-25-60		34. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery	
35. LOCATION (City, town, or county) Bergen County, New Jersey		36. FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY		37. ADDRESS Bethesda, Maryland	
38. REC'D BY REGISTRAR JUL 27 '60		39. REGISTRAR'S SIGNATURE Carlton S. Kenna			



8247

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08191

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 4833 West Lane		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4833 West Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Marjorie Middle Benton Last Lee			4. DATE OF DEATH Month July Day 13 Year 1960		
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1877		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) New Hampshire	
12. CITIZEN OF WHAT COUNTRY? US			13. FATHER'S NAME Charles Benton		
14. MOTHER'S MAIDEN NAME Elizabeth Barker			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Address Madeline Benton-neice-same 2d		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 2 years					INTERVAL BETWEEN ONSET AND DEATH 8 months
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of Rectum - 2 years					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 28, 1959 to July 13, 1960 , that (I) (we) last saw the deceased alive on July 13, 1960 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Neil P. Campbell		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED July 13, 1960	
22c. PHYSICIAN'S NAME (Type) Neil P. Campbell		22d. ADDRESS 3060 - 16th St. N.W.			
23a. BURIAL CREMATION REMOVAL (Specify) Cremation		23b. DATE THEREOF 7/16/60		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (City, town, or county) Suitland, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey			ADDRESS Bethesda, Maryland		
25a. REC'D BY REGISTRAR JUL 15 '60			25b. REGISTRAR'S SIGNATURE C. L. S. Knecht		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 14 days after death. Page 4 may be filed by the hospital or attending physician. The law requires that the death certificate be completed within 14 days after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



8123

CERTIFICATE OF DEATH

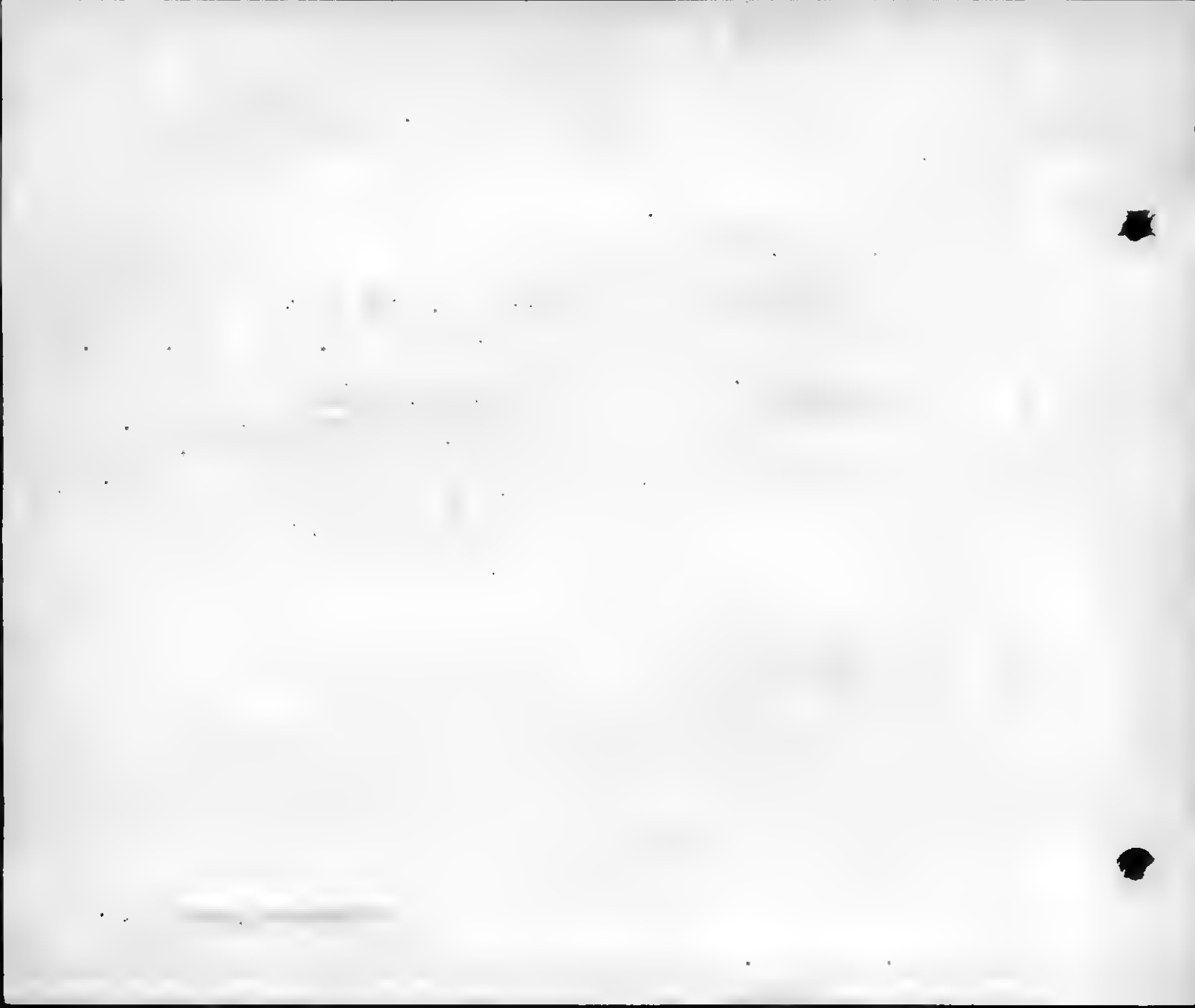
08192

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 6 wks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head			
f. STREET ADDRESS Green Meadows Court				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE REBECCA Lindner				4. DATE OF DEATH Month Day Year July 31 19 60			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1884	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS. Months Days Hours Min		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Charles H. Atz				14. MOTHER'S MAIDEN NAME Barbara Ellen Collins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO. none			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Multiple Cerebral Thromboses				INTERVAL BETWEEN ONSET AND DEATH 72 hrs			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 20, 1960 to July 31, 1960 that I last saw the deceased alive on July 31, 1960 and that death occurred at 4:45 p. m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau				ADDRESS (Street, city or town, state) 10609 CONCORD ST.			
PHYSICIAN'S NAME (Type) ROBERT T. THIBADEAU				DATE SIGNED Jul 31			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/2/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Prince Georges Co Md. 1960	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS Washington, D. C.		24a. REC'D BY REGISTRAR AUG 2 '60	
24b. REGISTRAR'S SIGNATURE C. S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

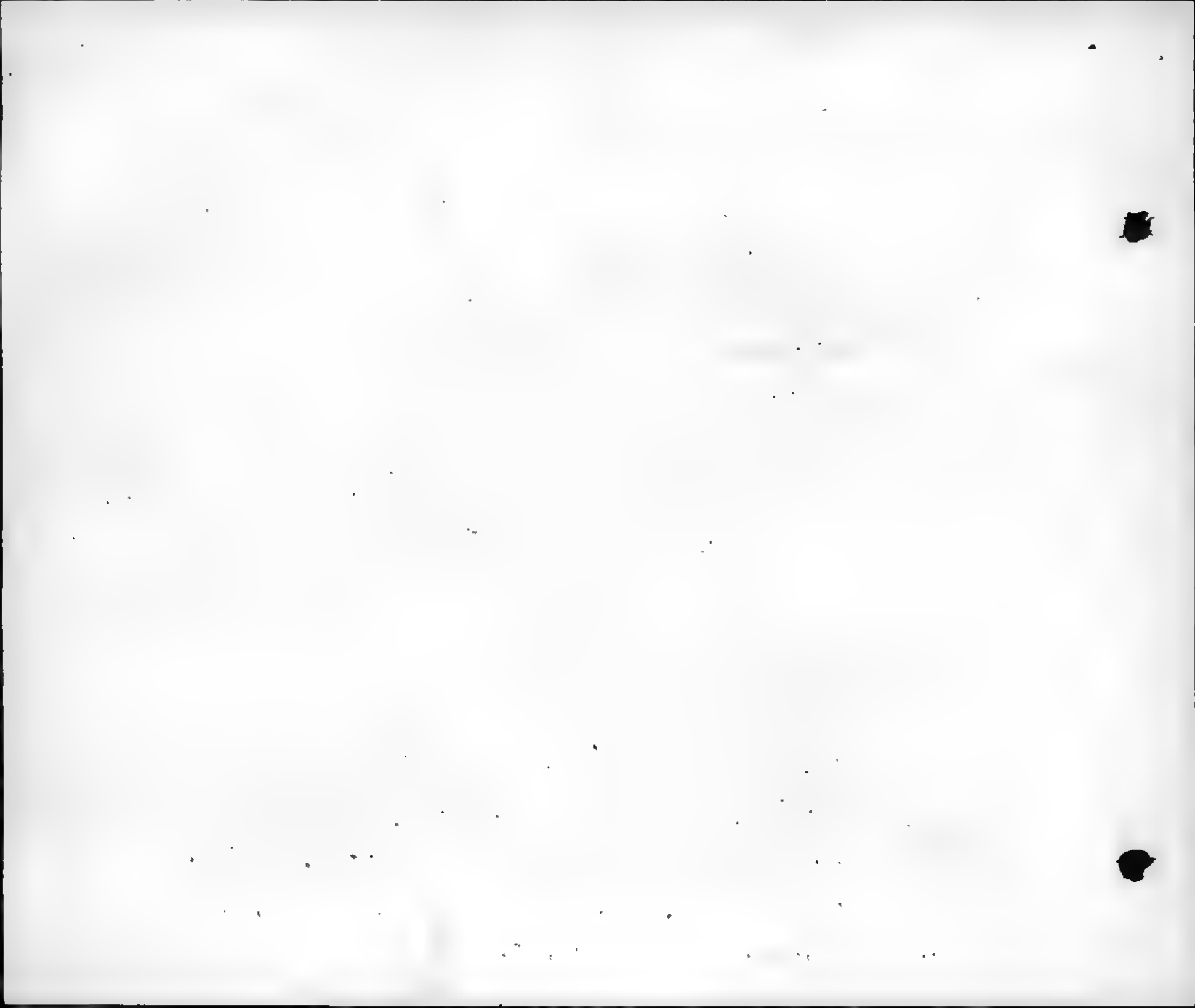
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8248 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

08193
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ellen Middle Sidney Last Lockhart		4. DATE OF DEATH Month July Day 31 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/9/82
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR: Months 78 Days 31 Hours 19 Min. 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY - own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Algernon Lockhart		14. MOTHER'S MAIDEN NAME Mary Evelyn Longacre	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus Ulcers		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 20 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3:15 p.m. to 7:30 p.m. , 19 60 , that I last saw the deceased alive on 3:15 p.m. 19 60 , and that death occurred at 7:30 p.m. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Murphy		DATE SIGNED 1 Aug 60	
PHYSICIAN'S NAME (Type) WILLIAM MURPHY			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 8/3/60	
22c. NAME OF CEMETERY OR CREMATORY MT. HEBRON CEMETERY		22d. LOCATION (City, town, or county) (State) WINCHESTER, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM E. PUMPHREY, INC.		24a. REC'D BY REGISTRAR Aug 5 '60	
ADDRESS SILVER SPRING, MD.		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

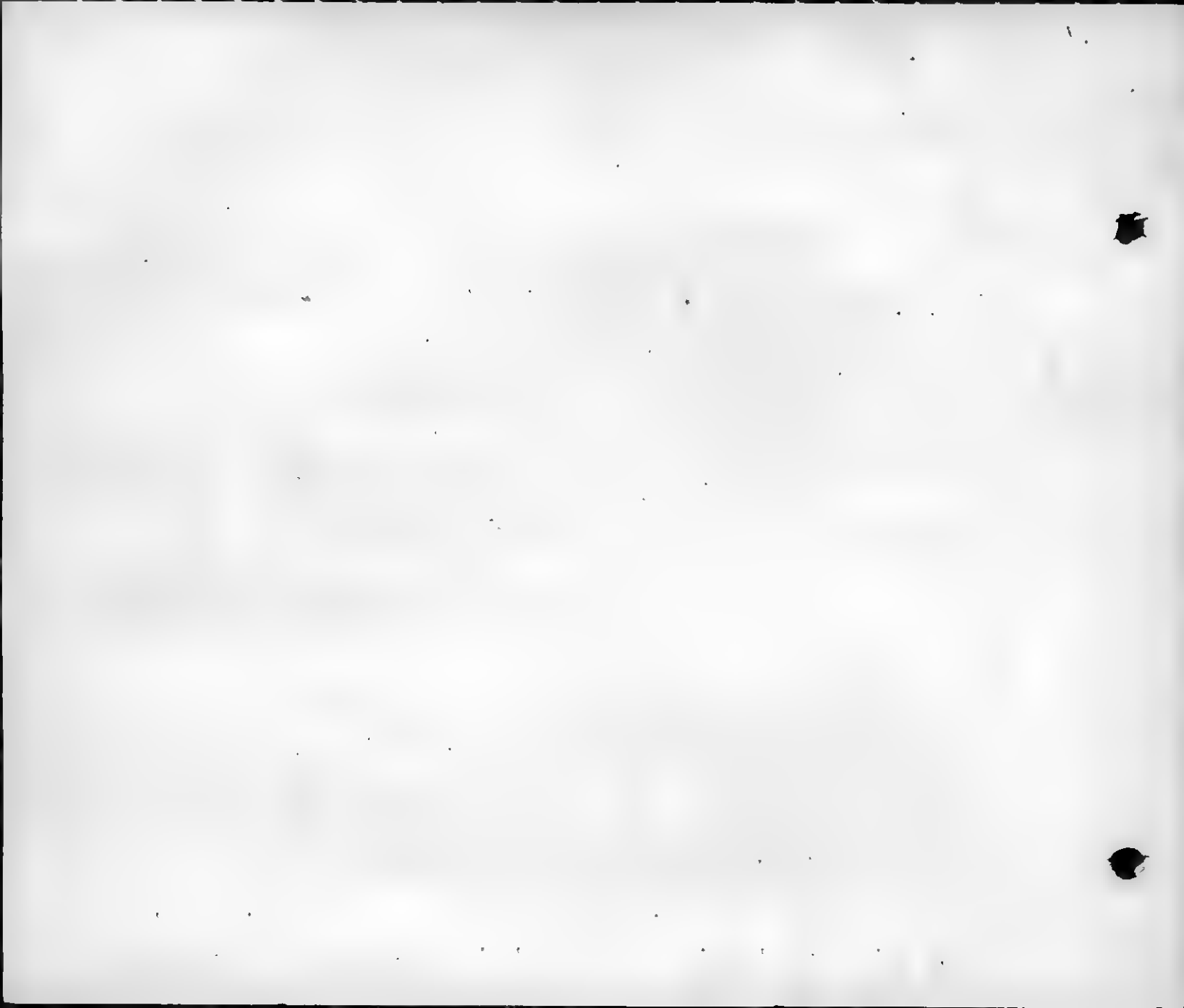
VR A15 (4)
15M 9/59

8145

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118194

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN 1b <u>1 day</u>				d. STREET ADDRESS <u>18830 Sudbury Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanatorium + Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Corrie GERTRUDE Lucas</u>				4. DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/27/85</u>	
9. AGE (In years last birthday) <u>74</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Henry Hawes</u>				14. MOTHER'S MAIDEN NAME <u>Florence Hawes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Hosp. Records - Washington San. & Hosp.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>							
DUE TO (b) <u>Coronary Artery Disease</u>							
DUE TO (c)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>7-28</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>July 27</u> 19 <u>60</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>				22b. DATE SIGNED <u>7-28-60</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>217 University Blvd E, H Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/1/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Fitzpatrick</u>				25a. REC'D BY REGISTRAR <u>AUG 3 '60</u>		25b. REGISTRAR'S SIGNATURE <u>C. S. Hume</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 filed 6-28-60

CERTIFICATE OF DEATH

Reg. Dist. No.

08188

8184

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 Lincoln Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AMANDA Middle V. Last LUCKETT		4. DATE OF DEATH Month July Day 25 Year 19 60	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1874
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Peter Nelson		14. MOTHER'S MAIDEN NAME Martha ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
INFORMANT William G. Lockett		Address Lincoln Ave., Rockville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Congestive Heart Failure DUE TO (c) C.S. CVD & Hypertension			INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 yrs 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 2/1/1950 to 7/25/1960 that I last saw the deceased alive on 7/25/1960 and that death occurred at 6:45 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Stephen R. Jones		ADDRESS (Street, city or town, state) Rockville, Md.	
PHYSICIAN'S NAME (Type) Robert L. Snowden		DATE SIGNED 7/28/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/28/60	22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,	22d. LOCATION (City, town, or county) (State) Rockville, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden		24a. REC'D BY REGISTRAR DATE AUG 2 '60	
ADDRESS Rockville, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

8124

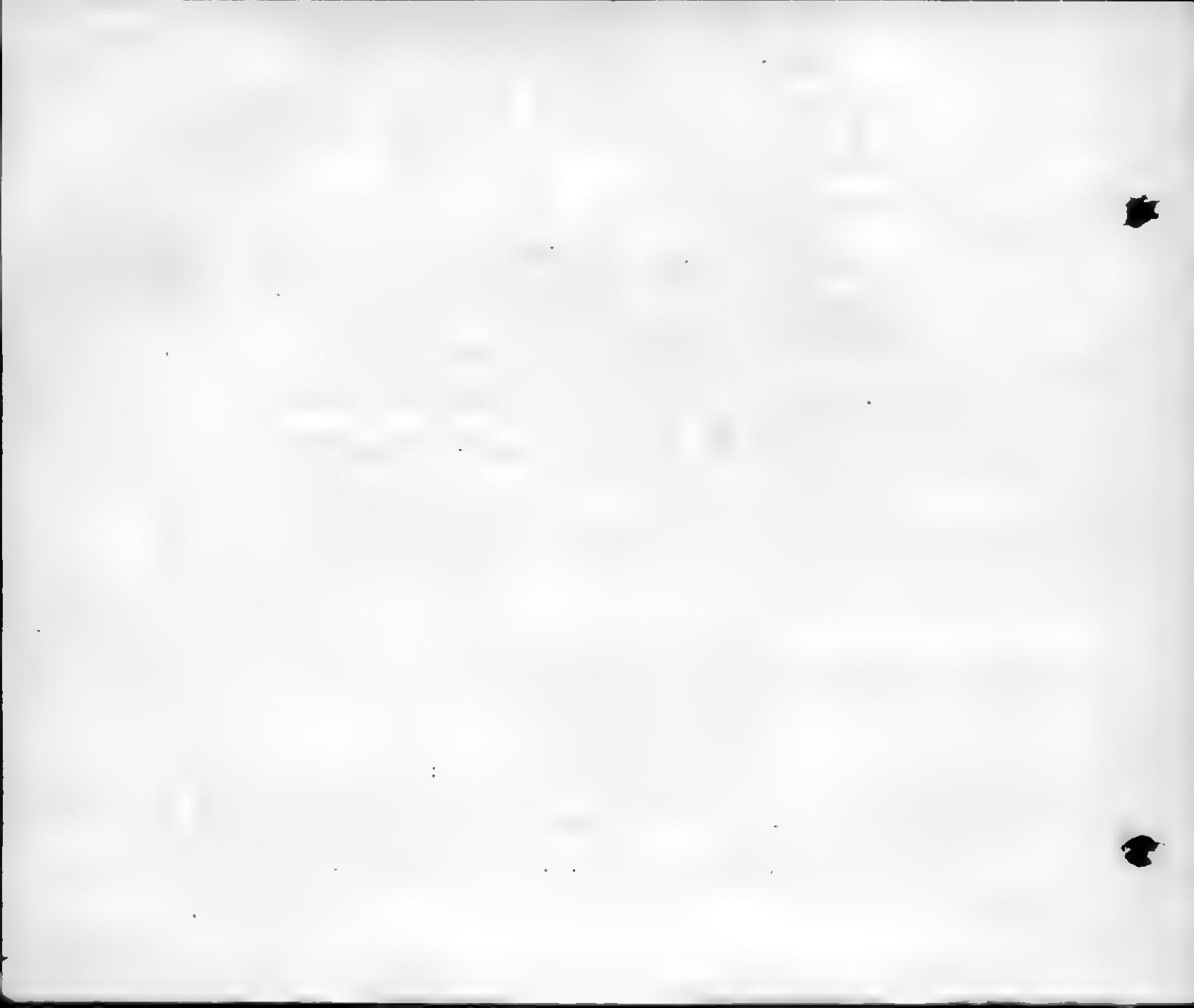
CERTIFICATE OF DEATH

Reg. Dist. No.

08195

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION LeDeau Gardens Nursing Home				d. STREET ADDRESS 11505 Schuylkill Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Roger Middle W. Last Lusby sr.				4. DATE OF DEATH Month July Day 4 Year 1960			
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb./6/1884		9. AGE (In years lost birthday) 76 yrs	IF UNDER 1 YEAR Months 76 Days 76 Hours 76 Min.	IF UNDER 24 HRS Hours 76 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drugs		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard H. Lusby				14. MOTHER'S MAIDEN NAME Georgiana Standbury			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 579-12-9539		INFORMANT Address Roger W. Lusby, jr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Arteriosclerosis, Generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple Small Cerebral Vascular Occlusions (c) Multiple Small Cerebral Vascular Occlusions							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 19, 1959 to July 4, 1960 , that I last saw the deceased alive on July 2, 1960 , and that death occurred at 4:50 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert T. Thibadeau M.D.				ADDRESS (Street, city or town, state) 10602 Concord Street Kensington, Maryland			
DATE SIGNED July 4-1960							
PHYSICIAN'S NAME (Type) Robert T. Thibadeau, M.D.				Kensington, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. LEE				ADDRESS 300 47th ST NW DC		24a. REC'D BY REGISTRAR DATE JUL 6 '60	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8164

Item 1 Film G267 7-21-60 et

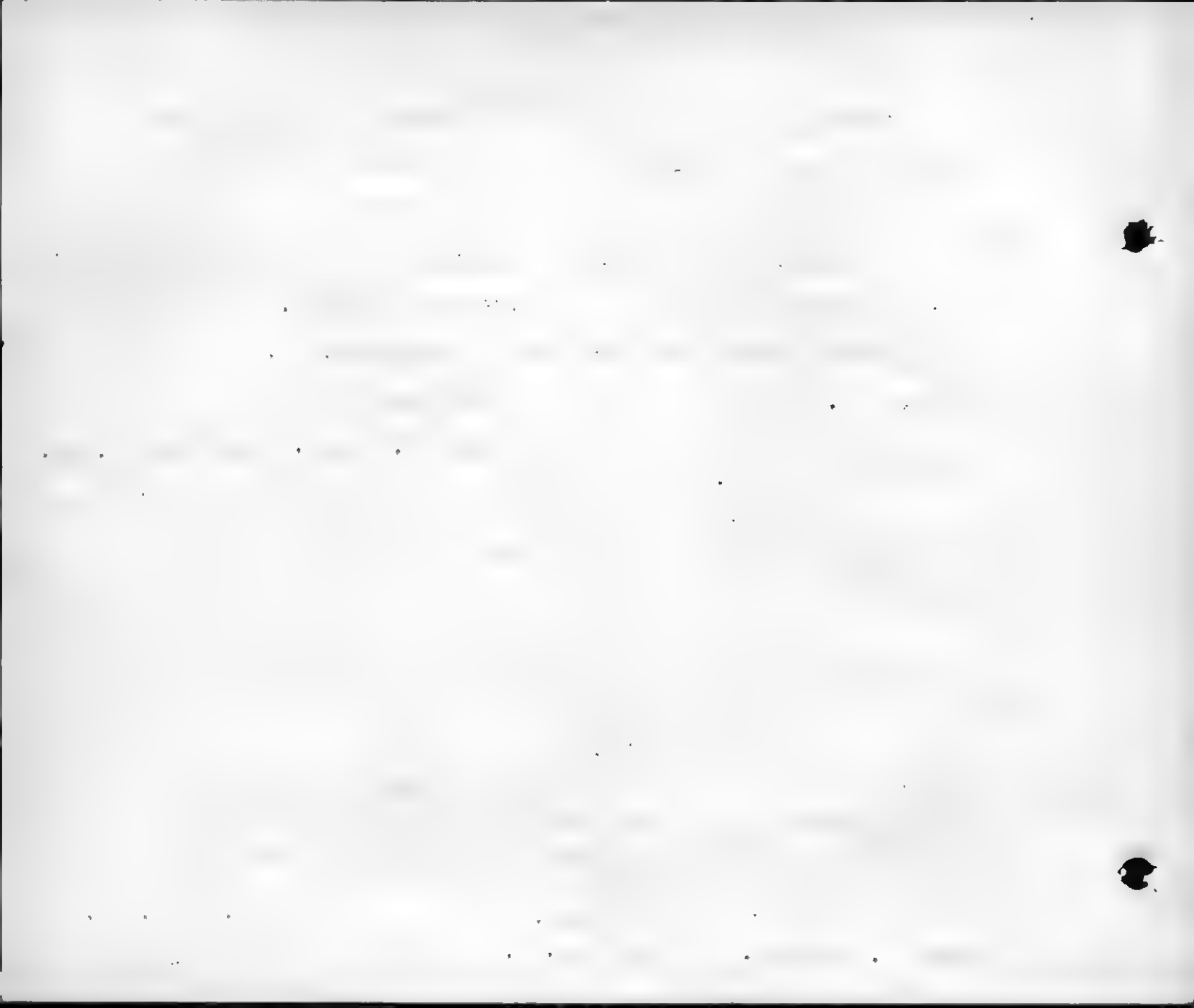
CERTIFICATE OF DEATH

Reg. Dist. No.

18193

1 PLACE OF DEATH a. COUNTY Montg MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg				c. LENGTH OF STAY IN TB 11 Yrs			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION 40 Summit Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First James Middle Paul Last Lynch				4. DATE OF DEATH Month July Day 11 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug* App 22-1896.64	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 2 Days 19 Hours Min 		11. IF UNDER 24 HRS Months Days Hours Min 		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic Manager Federal Reserve Board				10b. KIND OF BUSINESS OR INDUSTRY Washington, D.C.			
13. FATHER'S NAME Michael J. Lynch				14. MOTHER'S MAIDEN NAME Ida Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Constance E. Lynch, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis, Acute 4 years DUE TO (b) Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerotic Heart Disease				INTERVAL BETWEEN ONSET AND DEATH 45 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 15, 1960 to July 11, 1960 that I last saw the deceased alive on July 11, 1960 , and that death occurred at 4:00 M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Jack Schumacher M.D.				ADDRESS (Street, city or town, state) 105 Russell Ave. 7-13-60 DATE SIGNED			
PHYSICIAN'S NAME (Type) Jack Schumacher M.D. Gaithersburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 14-60		22c. NAME OF CEMETERY OR CREMATORY Neelsville.		22d. LOCATION (City, town, or county) (State) Germantown, Rural. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ernest C. Gartner. Gaithersburg, Md.				24a. REC'D BY REGISTRAR JUL 18 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kneass	

MEDICAL CERTIFICATION



FOR STATE
HEALTH DEPT.

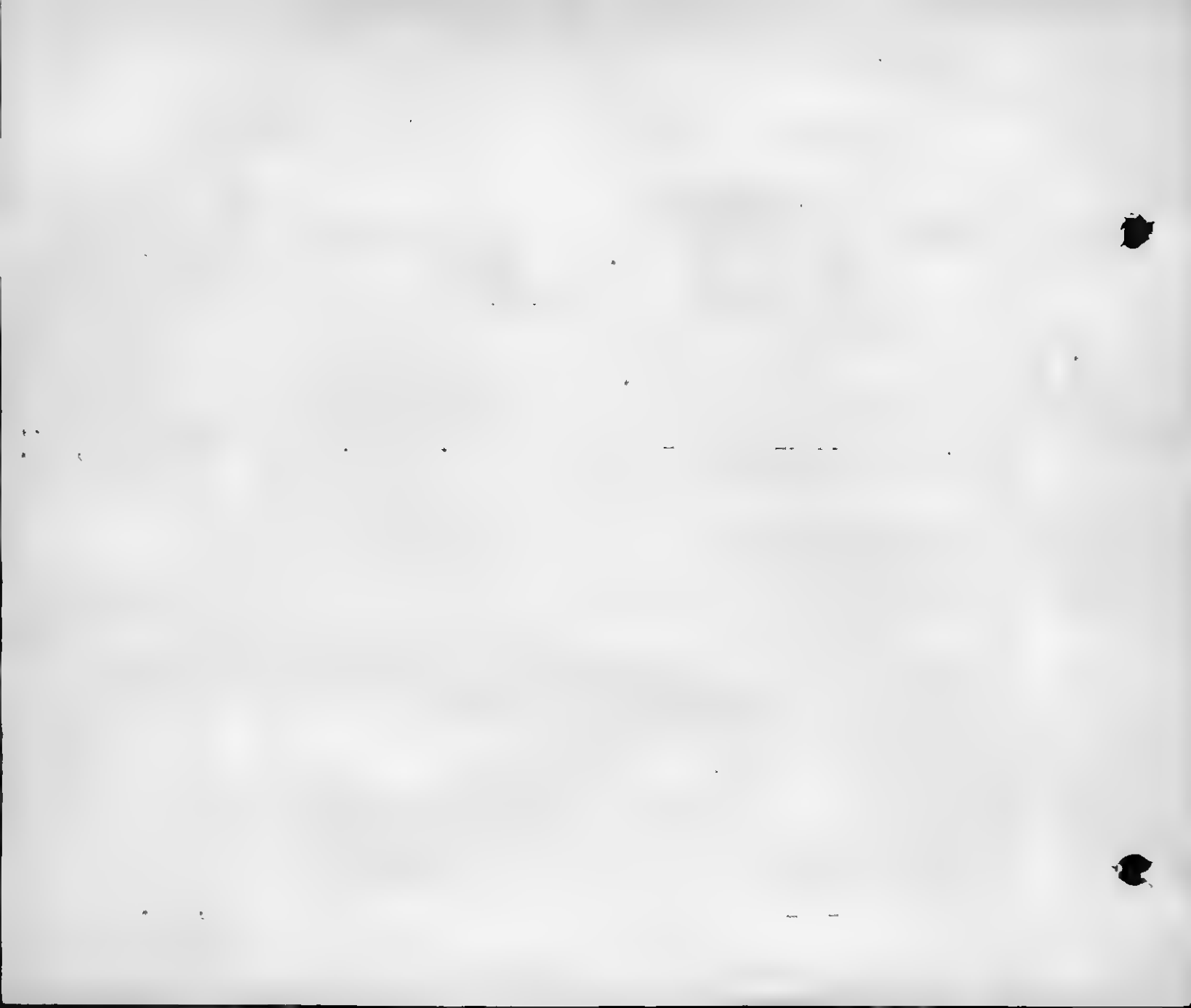
TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5426 Wisconsin Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOSEPH A. LYNCH		4. DATE OF DEATH July 26 1960		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-1903	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Manager		10b. KIND OF BUSINESS OR INDUSTRY Chevy Chase Land Co.		9. AGE (In years last birthday) 57	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Francis Lynch	
14. MOTHER'S MAIDEN NAME Jane McCarthy		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 183-03-4992	
17. INFORMANT Leo W. Lynch.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 20.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) few min. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John W. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 26 July 60	
EXAMINER'S NAME (Type) Joseph G. Ball		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL Removal		22b. DATE THEREOF 7-29-1960		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery	
22d. LOCATION (City, town, or country) (State) Philadelphia, Pa.		23. FUNERAL DIRECTOR Joseph G. Ball		24. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION



1 FOR STATE HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Echo Hts</u> c. LENGTH OF STAY IN IL <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6432 Wiscasset Hts</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>19006 Buxedette Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anthony William March Jr</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1-23-43</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>July 10 1960</u> Month Day Year 9. AGE (If last birthday) <u>17</u> yrs. 10. UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) <u>DC</u> 12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <u>Anthony Wm March</u> 14. MOTHER'S MAIDEN NAME <u>Margorie Walker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>A.W. March (father)</u> <u>John 2</u> Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Contusions and lacerations</u> DUE TO (b) <u>Multiple fractures of Skull</u> DUE TO (c) <u>Gunshot wound</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accidentally shot with 32 cal. rifle</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>5:20 p.m. 7-10 1960</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. City or town <u>Glen Echo Hts</u> (County) <u>montg</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Boschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7-11-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BOSCHART</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/13/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>	
22d. LOCATION (City, town, or country) <u>Arlington, Virginia</u> (State)		23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 12 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



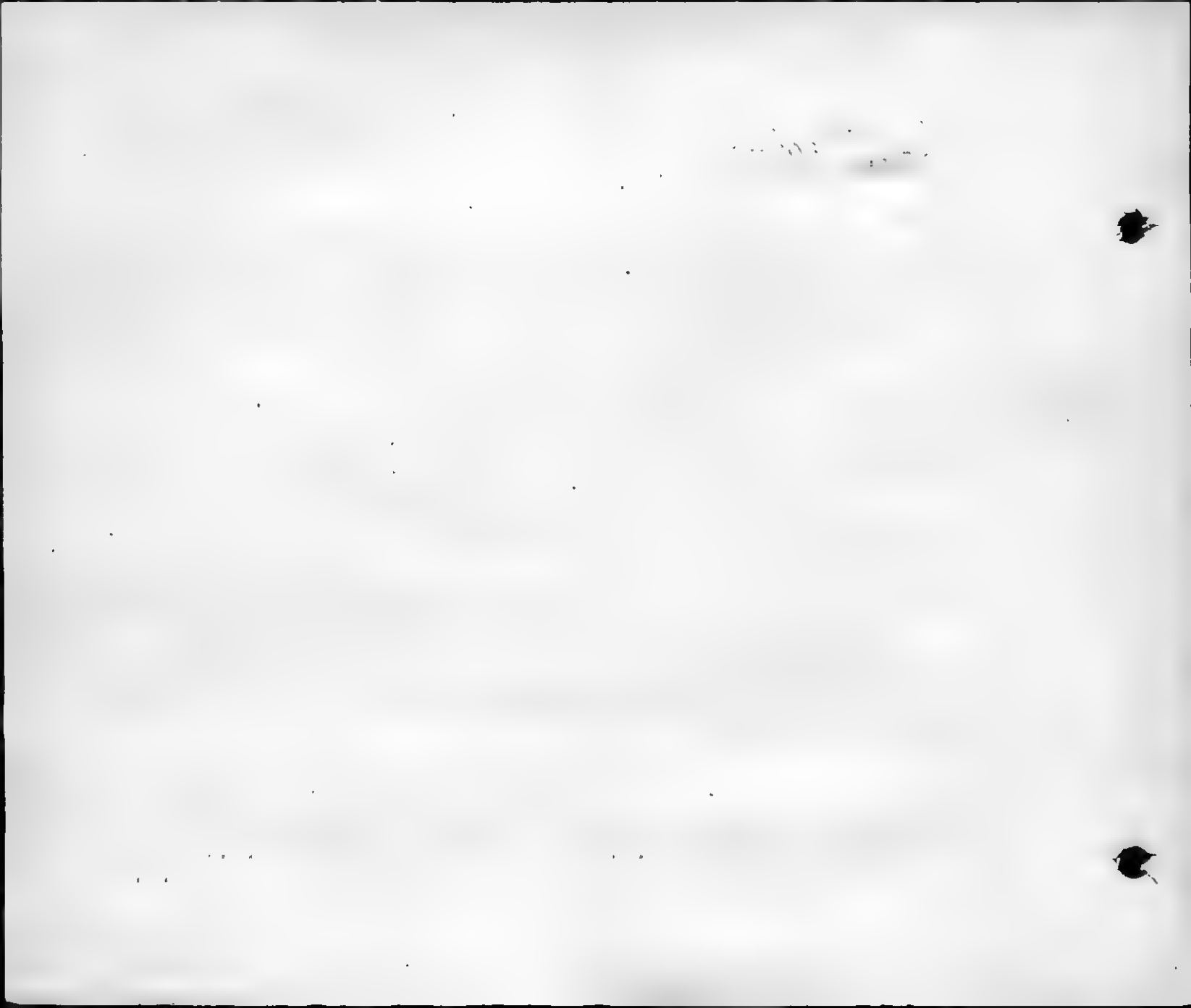
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08199

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>City of Wheaton</u>				c. LENGTH OF STAY IN 1b <u>1 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WHEATON NURSING Home</u>				d. STREET ADDRESS <u>2205 42nd ST.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLA</u> <u>MOORE</u> <u>MARSHALL</u>				4. DATE OF DEATH Month Day Year <u>July</u> <u>20</u> <u>1960</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/1885</u>	9. AGE (in years last birthday) <u>75</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>1 VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME <u>George Thomas Marshall</u>				14. MOTHER'S MAIDEN NAME <u>EMMA ROGERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Gladys B. Marshall</u>		Address <u>2205-42nd St. NW Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Cerebral Thrombosis</u> DUE TO <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Extension - Venous</u> DUE TO <u>—</u> (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>6/15/59</u> to <u>7/24/1960</u> that (I) (we) last saw the deceased alive on <u>7/14/1960</u> and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>E. Stuart Lyddane</u>		M.D.	ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>E. Stuart Lyddane M.D.</u>		22d. ADDRESS <u>3066 Que Street N.W., Washington D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>7/20/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Williamsburg, Va - Marshall Cemetery</u>		23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Sanders Jones</u>		ADDRESS <u>1756 Pa. Ave. NW D.C.</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>E. Stuart Lyddane</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

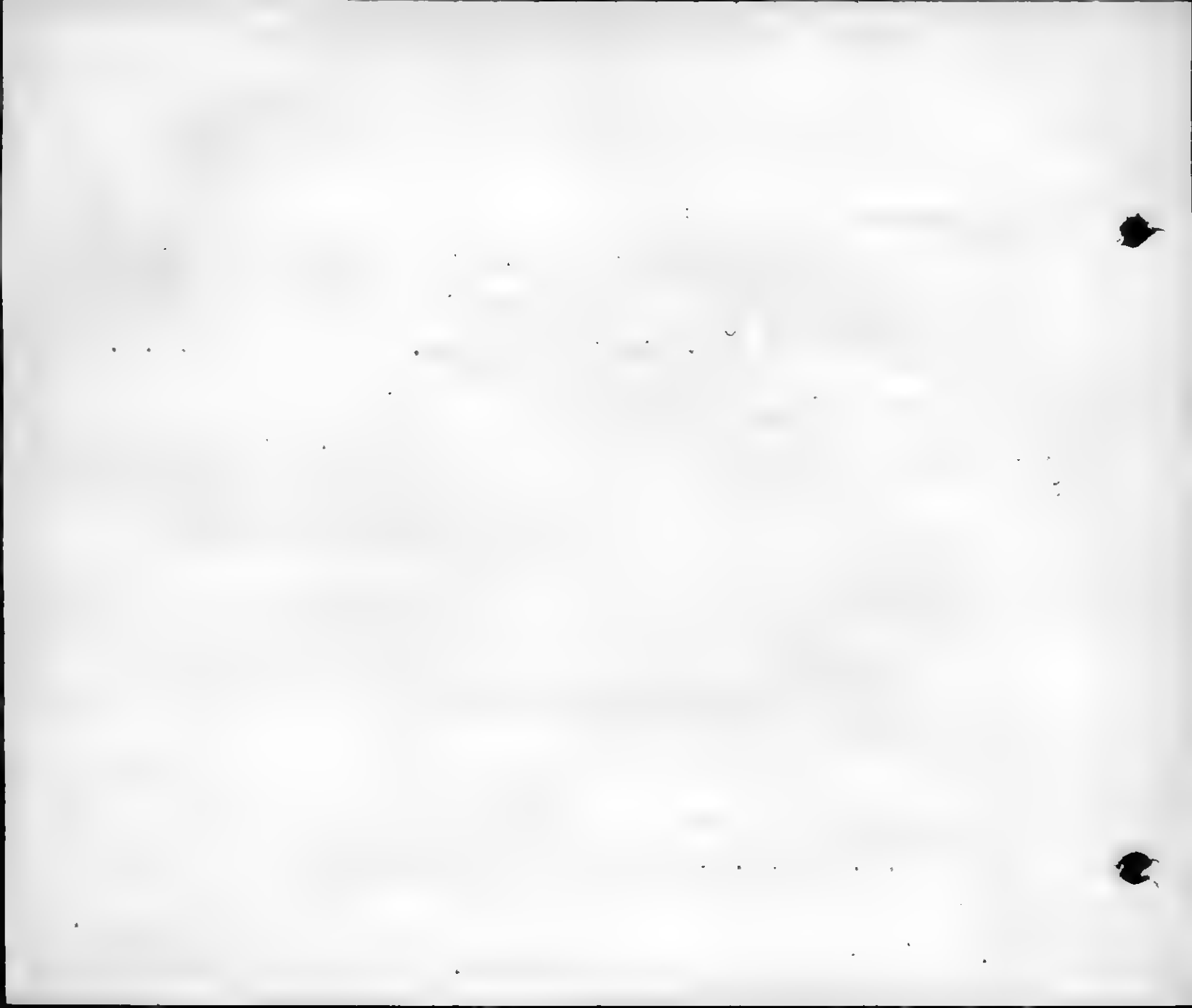
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08200

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DERWOOD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				e. STREET ADDRESS Box 63			
3. NAME OF DECEASED (Type or print) First Middle Last JESSIE BELLE MARSHALL				4. DATE OF DEATH Month Day Year JULY 3 1960			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/90		9. AGE (In years lost birthday) 69 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry				10b. KIND OF BUSINESS OR INDUSTRY Com. Laundry		11. BIRTHPLACE (State or foreign country) TENN.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME KAYO SMITH			
14. MOTHER'S MAIDEN NAME MARY HIGGINS				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 408 14 6997				17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Branchial Asthma & Congestive Failure DUE TO Chronic Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH 15 min 2 wks. yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS A POSTMORTEM PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 5/3 to 7/3 19 60 that (I) (we) last saw the deceased alive on 7/3 19 60 , and that death occurred at 6 P.M., from the causes and on the date stated above.							
22a. SIGNATURE C. H. LIGON, M. D.				22b. DATE SIGNED 7/4/60		22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.	
22d. ADDRESS SANDY SPRING, MD.				22e. DATE SIGNED 7/4/60			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6 1960		23c. NAME OF CEMETERY OR CREMATORY Laytonsville		23d. LOCATION (City, town, or county) (State) Laytonsville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis X Barber				24a. ADDRESS Laytonsville, Md.		24b. REC'D BY REGISTRAR JUL 7 '60	
24c. REGISTRAR'S SIGNATURE Charles S. Hume				24d. DATE JUL 7 '60			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

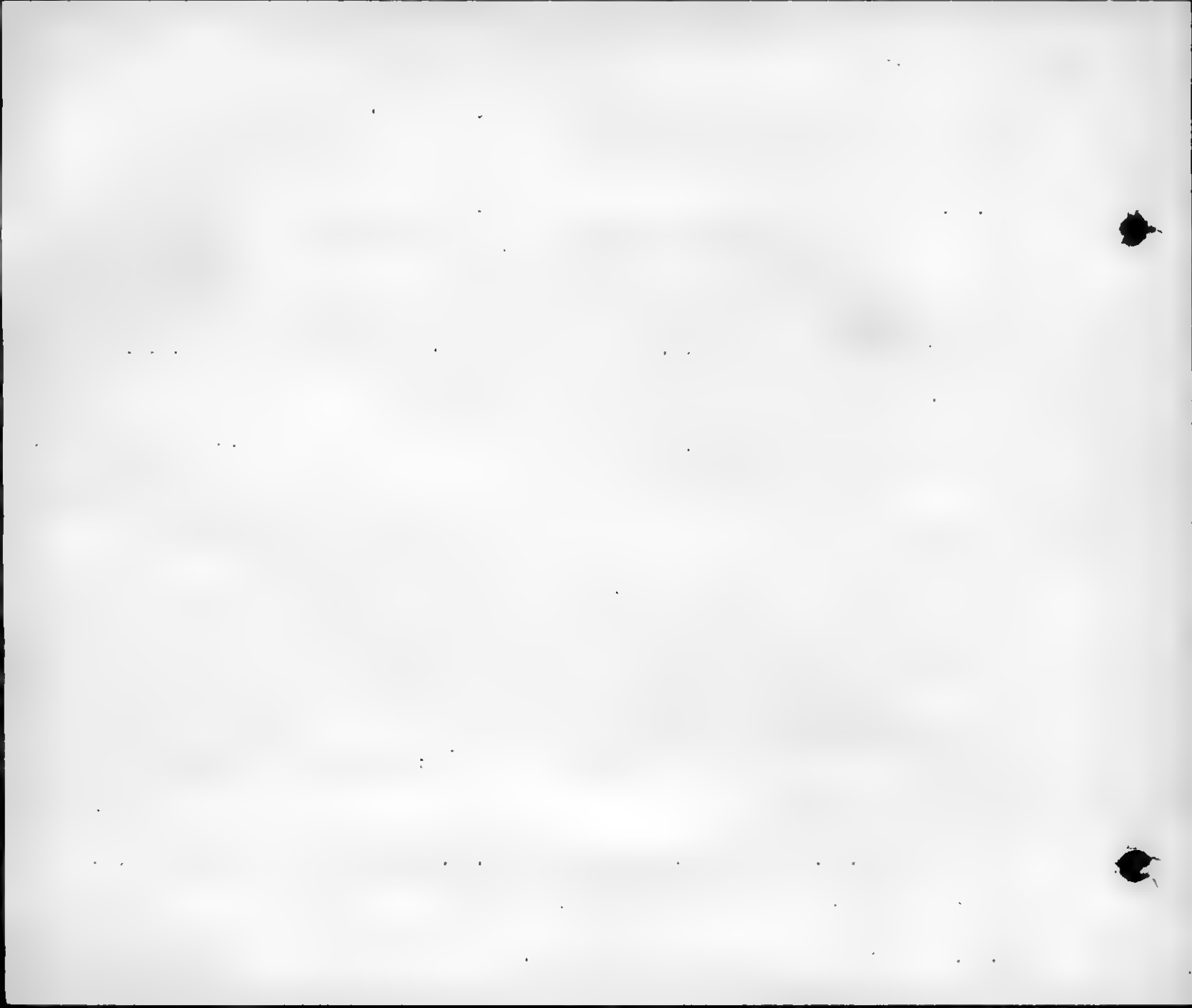
8252

08241

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 44 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE South Carolina b. COUNTY Timmons c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timmons d. STREET ADDRESS Rt. 2, Box 212 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alton Durwood MATTHEWS		4. DATE OF DEATH Month Day Year July 25 1960	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-23-04
9. AGE (In years lost birthday) yrs 56		10. IF UNDER 1 YEAR Months Days Hours Min. 7 7 1 3	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) Rigger		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Toy S. Matthews		14. MOTHER'S MAIDEN NAME Laura Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 247-16-5444	
17. INFORMANT (D) Mrs. Carolyn Thompson, Rt. 5, Darlington, S.C.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Melanoma, Malignant 190.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH 7 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 8:55 p. m. 1960	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 11 1960 to July 25 1960 , that (I) (we) last saw the deceased alive on July 25 1960 , and that death occurred at 8:55 AM , from the causes and on the date stated above.			
22a. SIGNATURE R. C. Thomas		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) R. C. THOMAS, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-26-60	23c. NAME OF CEMETERY OR CREMATORY Cartersville Cemetery	23d. LOCATION (City, town, or county) (State) Cartersville South Carolina
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR DATE JUL 28 '60	25b. REGISTRAR'S SIGNATURE Charles S. Thomas

1

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8253

CERTIFICATE OF DEATH

118262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Pr. George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>42 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		16	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reister Hosp. and Sanitarium</u>				d. STREET ADDRESS <u>11525 Montgomery Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Abbie</u> Middle <u>F.</u> Last <u>May</u>				4. DATE OF DEATH Month <u>July</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 9, 1876</u>		9. AGE (In years last birthday) <u>87 yrs</u>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John King</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Eugene May, same as 2a</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COMMON ACUTE STROKE (TOXEMIA)</u> DUE TO <u>660X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO <u>1 yr.</u> (c) <u>Chronic Pyelonephritis</u> <u>6 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>5-11-60</u> , 19 <u>60</u> , to <u>7-10-</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>July 10</u> , 19 <u>60</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>915-19th St. N.W. Wash. D.C.</u> DATE SIGNED <u>7/11/60</u>							
ACTUAL SIGNATURE <u>Maurice Protas</u> M.D.				PHYSICIAN'S NAME (Type) <u>Maurice Protas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		22d. LOCATION (City, town, or county) (State) <u>Pr. Geo. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co.</u>				ADDRESS <u>Riverdale, Md.</u>		24. REC'D BY REGISTRAR DATE <u>JUL 12 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>							



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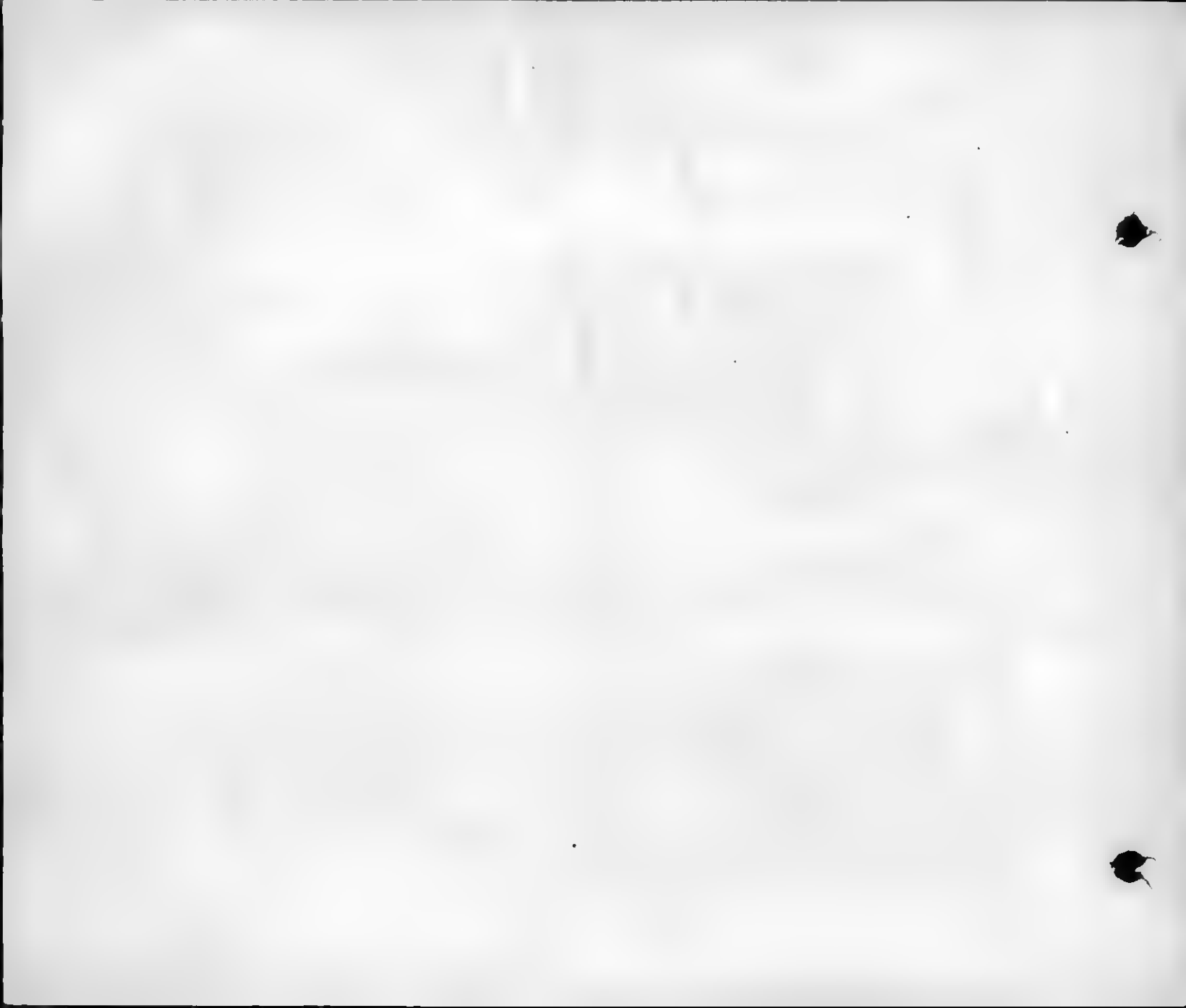
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONT. CO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN <u>4 days 6 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp</u>				d. STREET ADDRESS <u>8218-Larry Pl.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Marshall Mayes</u>				4. DATE OF DEATH <u>July 27 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/14/1897</u>	9. AGE (In years last birthday) <u>70</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. of Commerce Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter Marshall Mayes</u>				14. MOTHER'S MAIDEN NAME <u>Althea Allen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes World War</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mary B. Mayes</u> Address <u>same as 3 above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1955</u> to <u>July 27 1960</u> , that I last saw the deceased alive on <u>7-27-60</u> , and that death occurred at <u>4:25 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph A. Bailey</u> M.D.				ADDRESS (Street, city or town, state) <u>Washington Clinic</u> DATE SIGNED <u>7-27-60</u>			
PHYSICIAN'S NAME (Type) <u>Joseph A. Bailey</u>				<u>Western Ave. F.W. & H. Co. Wash, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Co. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co.</u> ADDRESS <u>3072 - M St. N.W. Wash, D.C.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>AUG 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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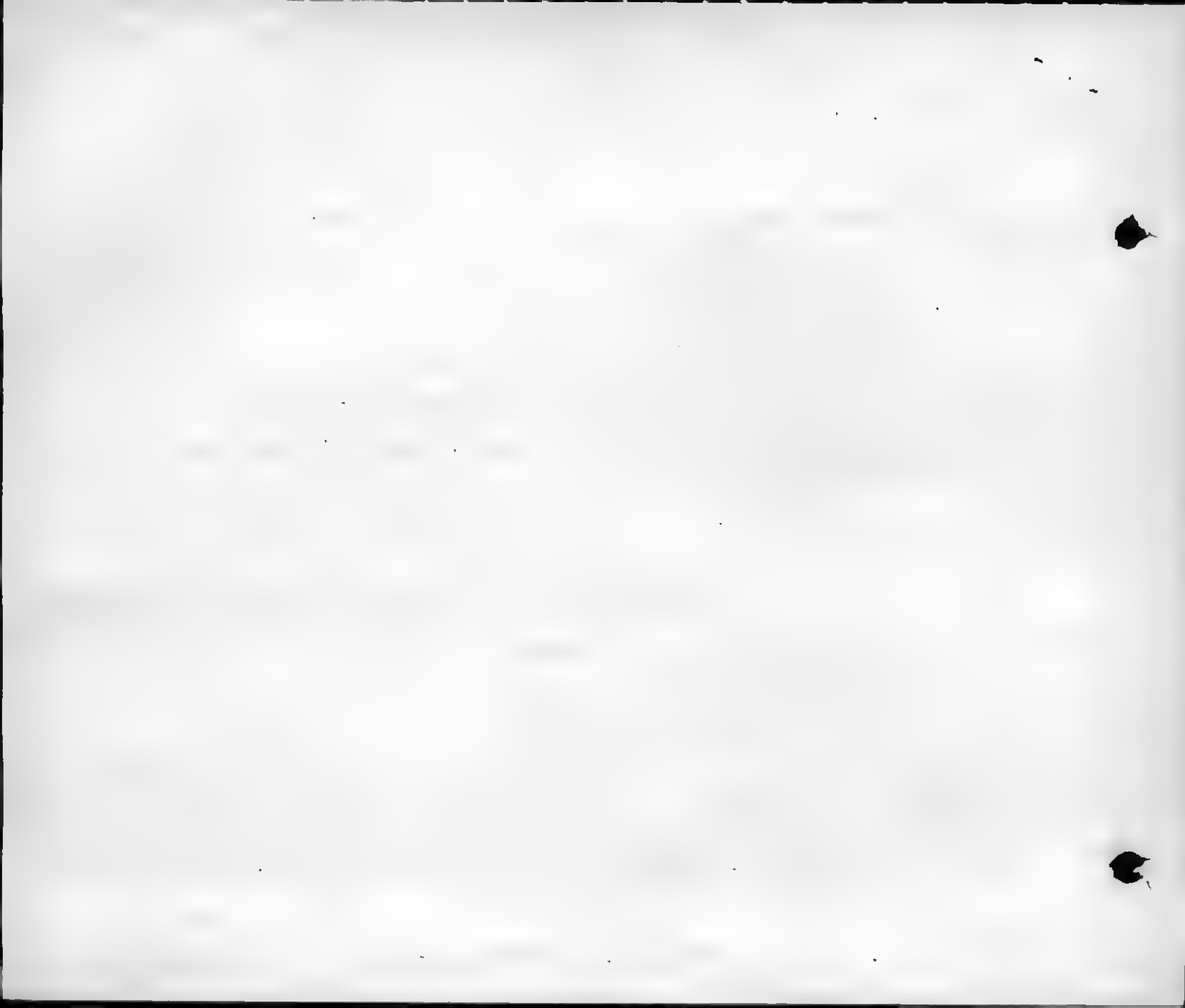
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118214

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 310 Nimitz Road				e. STREET ADDRESS 310 Nimitz Road			
3. NAME OF DECEASED (Type or print) First Frances Middle M. Last Mayhew				4. DATE OF DEATH Month July Day 6 Year 1960			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 23, 1928	9. AGE (In years last birthday) 31 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rufus Cornwell, Sr.				14. MOTHER'S MAIDEN NAME Hattie V. Cummings			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Yes-Unknown		17. INFORMANT Amos W. Mayhew-Husband-same 2d			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute alcoholism DUE TO with 1) acidosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2) cirrhosis DUE TO liver (c)						INTERVAL BETWEEN ONSET AND DEATH 6 weeks 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 30, 1960 to July 6, 1960 that (I) (we) last saw the deceased alive on July 5, 1960 , and that death occurred at 7 AM , from the causes and on the date stated above.							
22a. SIGNATURE Patrick C. Jameison M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/6/60	
22c. PHYSICIAN'S NAME (Type) Patrick C. Jameison				22d. ADDRESS 12020 Georgia Ave. Silver Spring Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/9/60		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery		23d. LOCATION (City, town, or county) (State) Leesburg, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE JUL 8 '60	
				25b. REGISTRAR'S SIGNATURE Charles S. Kraus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08205

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE West Virginia b. COUNTY McDowell	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First David Middle James Last McColl		4. DATE OF DEATH Month July Day 1 Year 19 60	
5. SEX Male	6. COLOR OR RACE cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28 1960
9. AGE (In years last birthday) 4		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 4 Min 4	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		12. KIND OF BUSINESS OR INDUSTRY None	
13. FATHER'S NAME Ira N McColl		14. MOTHER'S MAIDEN NAME Carol Jean Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) pneumonia DUE TO (b) tracheoesophageal fistula (c) and prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days 4 days 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 30 6:05 to July 1 19 60 that (I) (we) last saw the deceased alive on July 1 19 60 , and that death occurred at 2 M, from the causes and on the date stated above.			
22a. SIGNATURE C. A. Broadus Jr. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type or print) C. A. Broadus Jr. CDR MC USN		22d. ADDRESS	
23a. BURIAL, CREMATON, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial-Shipment 7-3-60		McDowell Co. W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR JUL 6 '60	
25b. REGISTRAR'S SIGNATURE Robert L. Kline		25c. ADDRESS Bethesda, Md.	
25d. ADDRESS 7557 Wisc. Ave.		25e. ADDRESS	



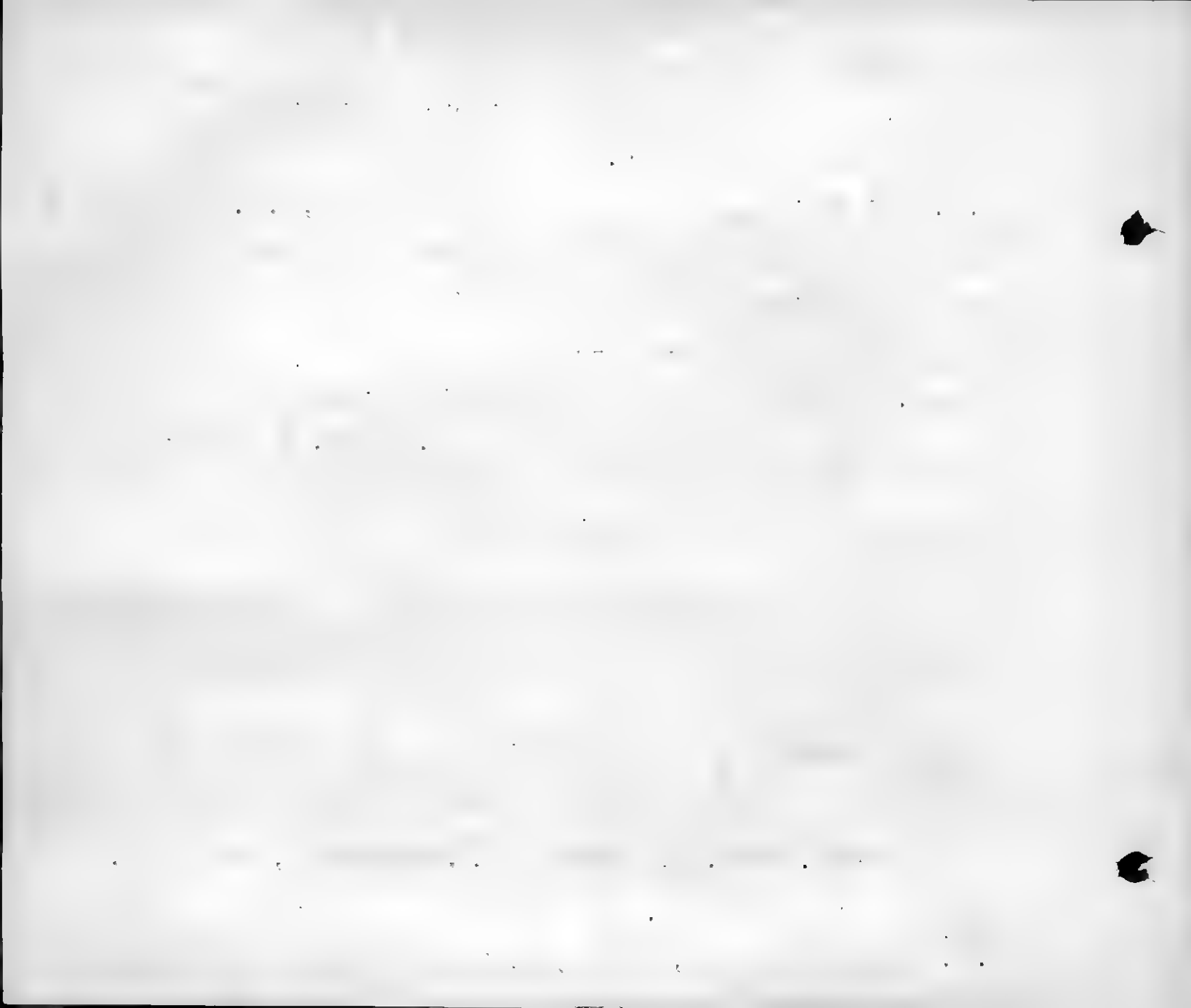
may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Item 3
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08206

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 2 hrs.		d. STREET ADDRESS 15 Barnacle Green, S. W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David MC GOWAN		4 DATE OF DEATH Month Day Year July 18 1960	
5 SEX Male	6 COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-18-60
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours 2 15	
10a. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene E. MC GOWAN		14. MOTHER'S MAMINE NAME Madeline Pearl MARQUIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT (F) Eugene E. McGowan, same as #2 above		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Neonatal Asphyxia DUE TO (b) Immaturity DUE TO (c) --- Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) postmortem attended the deceased from Birth to July 18 1960 , that (I) yes last saw the deceased alive on July 18 1960 , and that death occurred at 1:10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Fred W. Grello		22b. DATE SIGNED 7-18-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment	23b. DATE THEREOF 7-19-60	23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	23d. LOCATION (City, town, or county) (State) Worthington Minnesota
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		25a. REC'D BY REGISTRAR DATE JUL 20 '60	
25b. REGISTRAR'S SIGNATURE Charles E. Hume			



CERTIFICATE OF DEATH

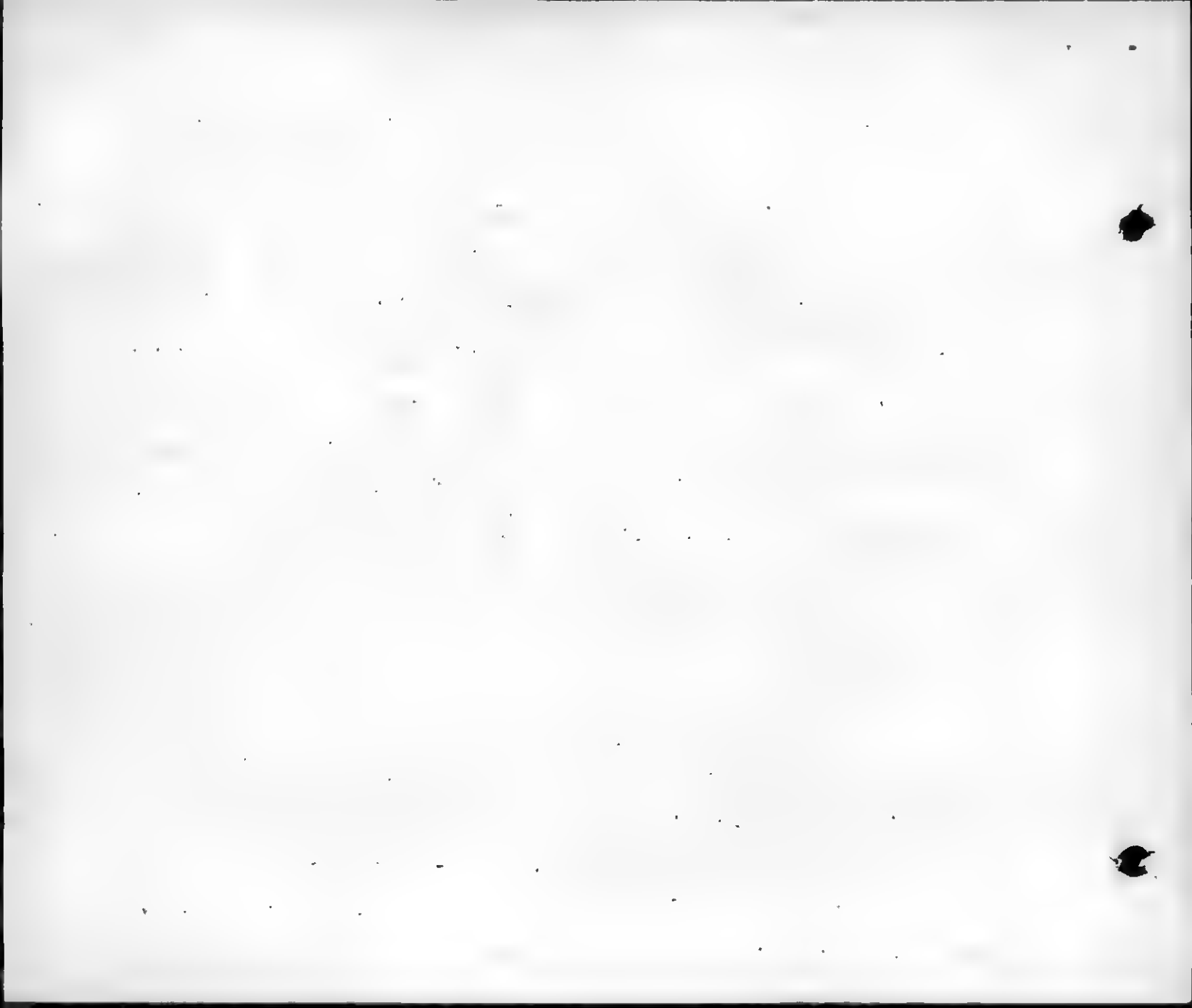
Reg. Dist. No. 08207

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
c. LENGTH OF STAY IN lb 3 days		d. STREET ADDRESS 6813 Connecticut Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Meixell Last Meixell		4. DATE OF DEATH Month July Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 23, 1884
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 11 Days 6 Hours Min. 	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Ephrath, Penn.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry J. Meixell		14. MOTHER'S MAIDEN NAME Strohl, Emma	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Ruth F. Meixell (Wife) Address As above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident DUE TO cerebral arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ? (c) ?		INTERVAL BETWEEN ONSET AND DEATH 7 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Sept. Day 19 Year 19 60 Hour o. m. p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that attended the deceased from Sept. 19 59 to July 29 1960 that I last saw the deceased alive on July 29 1960 , and that death occurred at 3:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George A. Gray, Jr. M.D.		ADDRESS (Street, city or town, state) 4740 Chevy Chase Drive, Md.	
PHYSICIAN'S NAME (Type) George A. Gray, Jr., M.D.		DATE SIGNED 1/29/60	
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF August 1, 1960	22c. NAME OF CEMETERY OR CREMATORY Parklawn	22d. LOCATION (City, town, or county) (State) Rockville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE AUG 1 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kinsler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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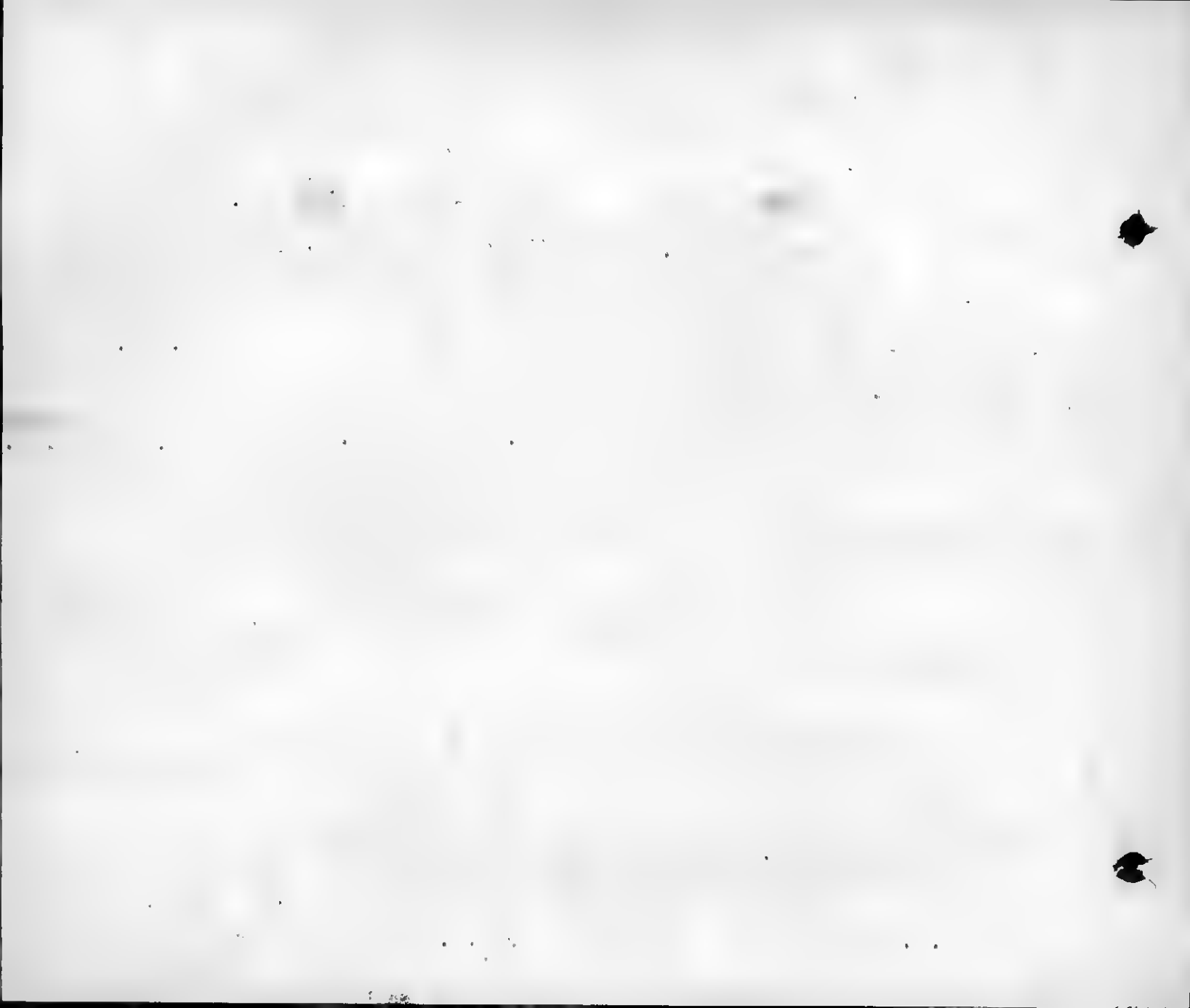
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8258

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

18268

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenwood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5200 Chamberlin Avenue				d. STREET ADDRESS 5200-Chamberlin Ave.			
3. NAME OF DECEASED (Type or print) First Joseph Middle H. Last Milans				4. DATE OF DEATH Month July Day 12 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/1877	9. AGE (In years last birthday) 82 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired- Patent Attorney				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph D. Milans				14. MOTHER'S MAIDEN NAME Lillian McPhearson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO no		17. INFORMANT Address Mrs. Gertrude B. Milans-5200 Chamberlin Ave. Kenwood, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemiplegia from Ruptured Pulmonary Artery 450.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized Arteriosclerosis DUE TO (c) 10 years INTERVAL BETWEEN ONSET AND DEATH 5 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left Hemiplegia of 12 years duration							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15, 1948 to July 12, 1960 , that (I) (we) last saw the deceased alive on Jan 10, 1960 , and that death occurred at 4:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Thomas S. Sappington M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Thomas S. Sappington	
22d. ADDRESS 1025 Conn. Ave N.W. Wash DC				22e. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 7/14/60		23c. NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Company				25a. REC'D BY REGISTRAR DATE JUL 13 '60		25b. REGISTRAR'S SIGNATURE Charles E. Hines	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

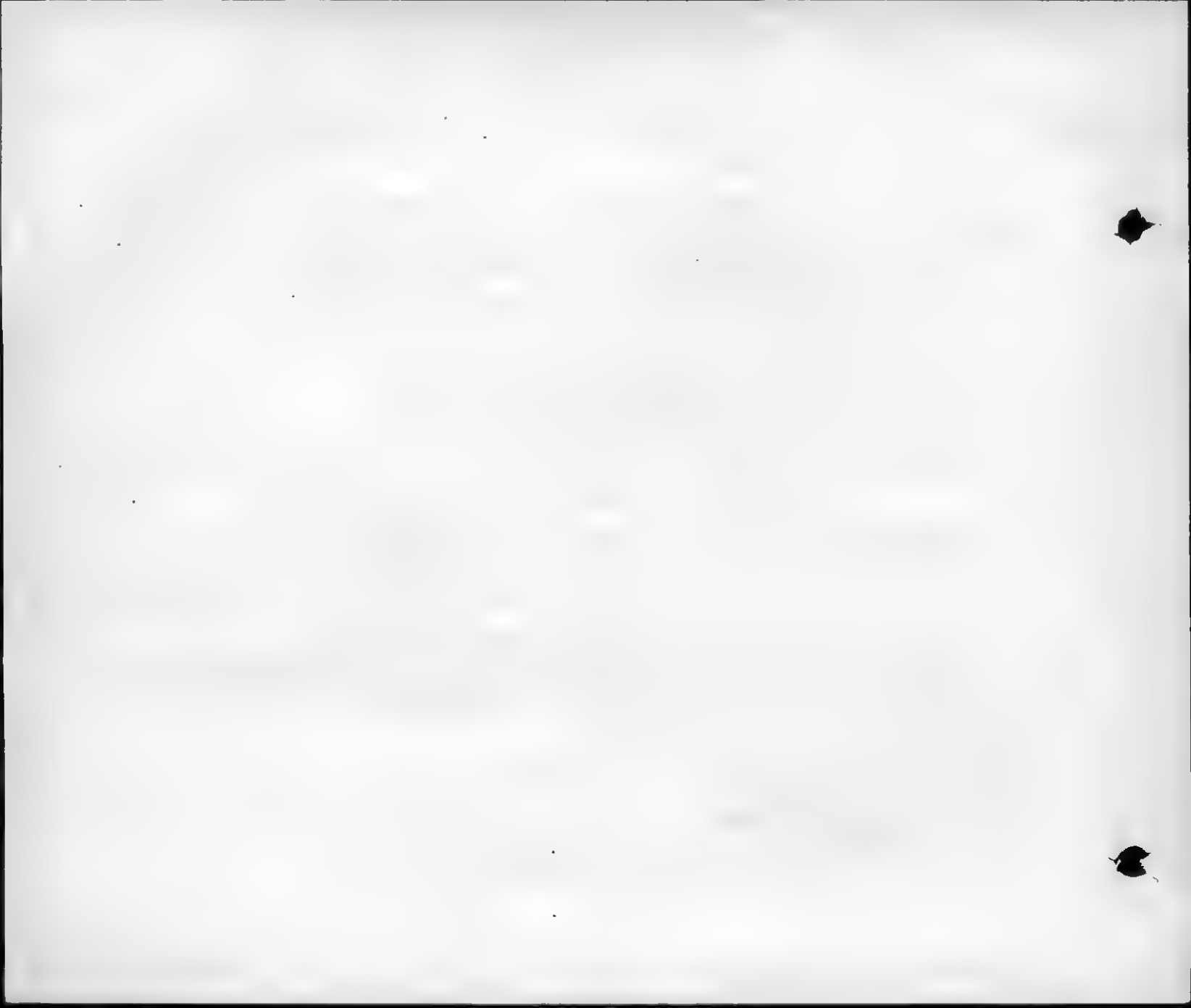
VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 7, MARYLAND
CERTIFICATE OF DEATH

8259

082113

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Miles Rd Burtonsville</u> c. LENGTH OF STAY IN 1b <u>BURTONSVILLE</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2910 - Miles Rd</u>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BURTONSVILLE</u> d. STREET ADDRESS <u>Miles Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Rose Caroline</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			4. DATE OF DEATH <u>July 14</u> 19 <u>60</u> Month Day Year 9. AGE (In years lost birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS 11. BIRTHPLACE (State or foreign country) <u>Howard Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>MARTIN Luther Iager</u>		14. MOTHER'S MAIDEN NAME <u>MARY Smith</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>ANNE MOSHER - 2910 - Miles Rd</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>4434</u> IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Hypertensive Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Urinary Infection</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> or work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12-20</u> 19 <u>59</u> to <u>7-14</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>7-13</u> 19 <u>60</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Roy B. Parsons Jr MD</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ROY B. PARSONS JR MD</u>		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 17, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>			
23d. LOCATION (City, town, or county) <u>Burtonsville Md</u>		(State)		23e. REC'D BY REGISTRAR			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edith E. Davidson</u>		ADDRESS <u>Land Md</u>		25a. REGISTRAR'S SIGNATURE <u>William S. Hume</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

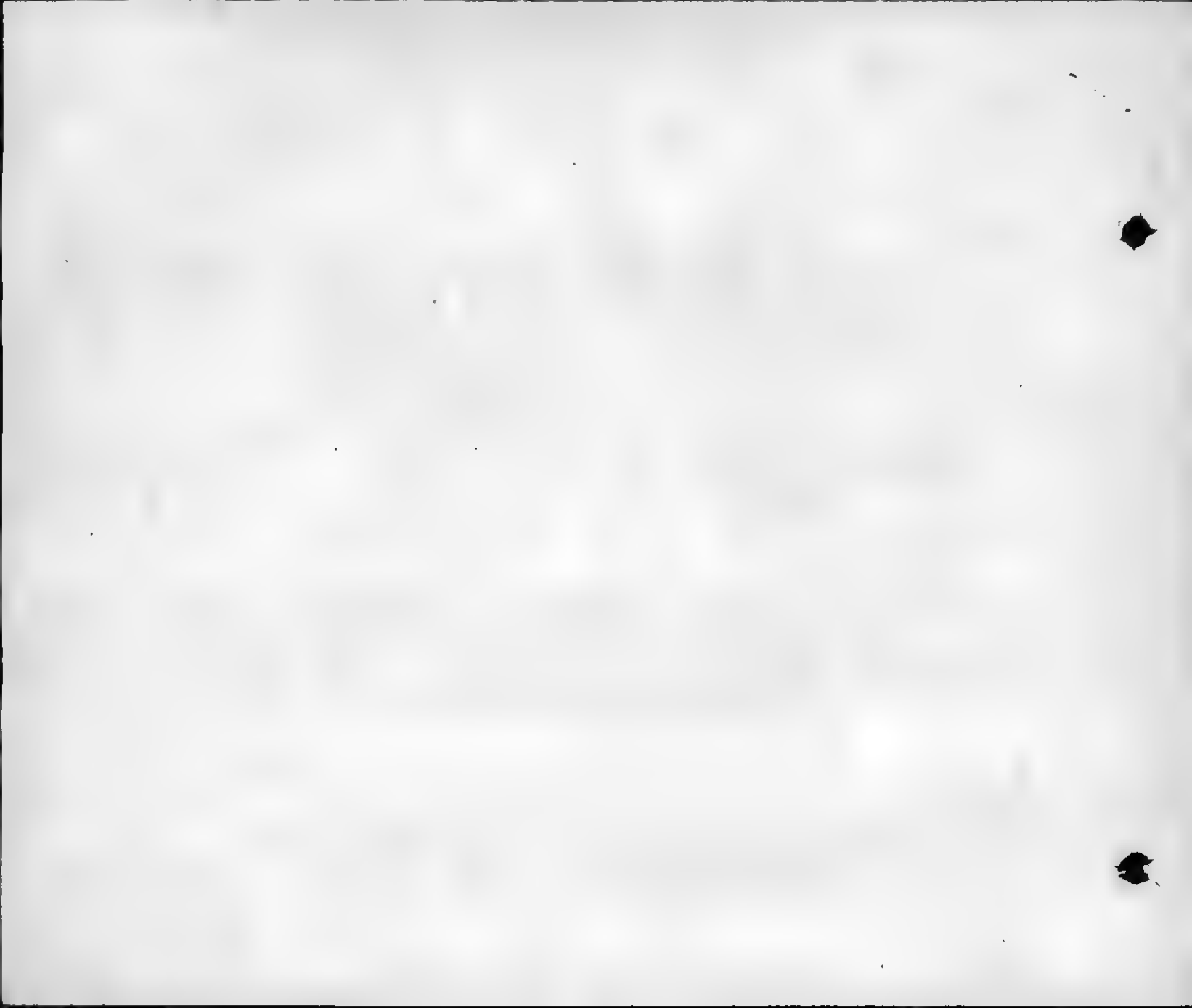
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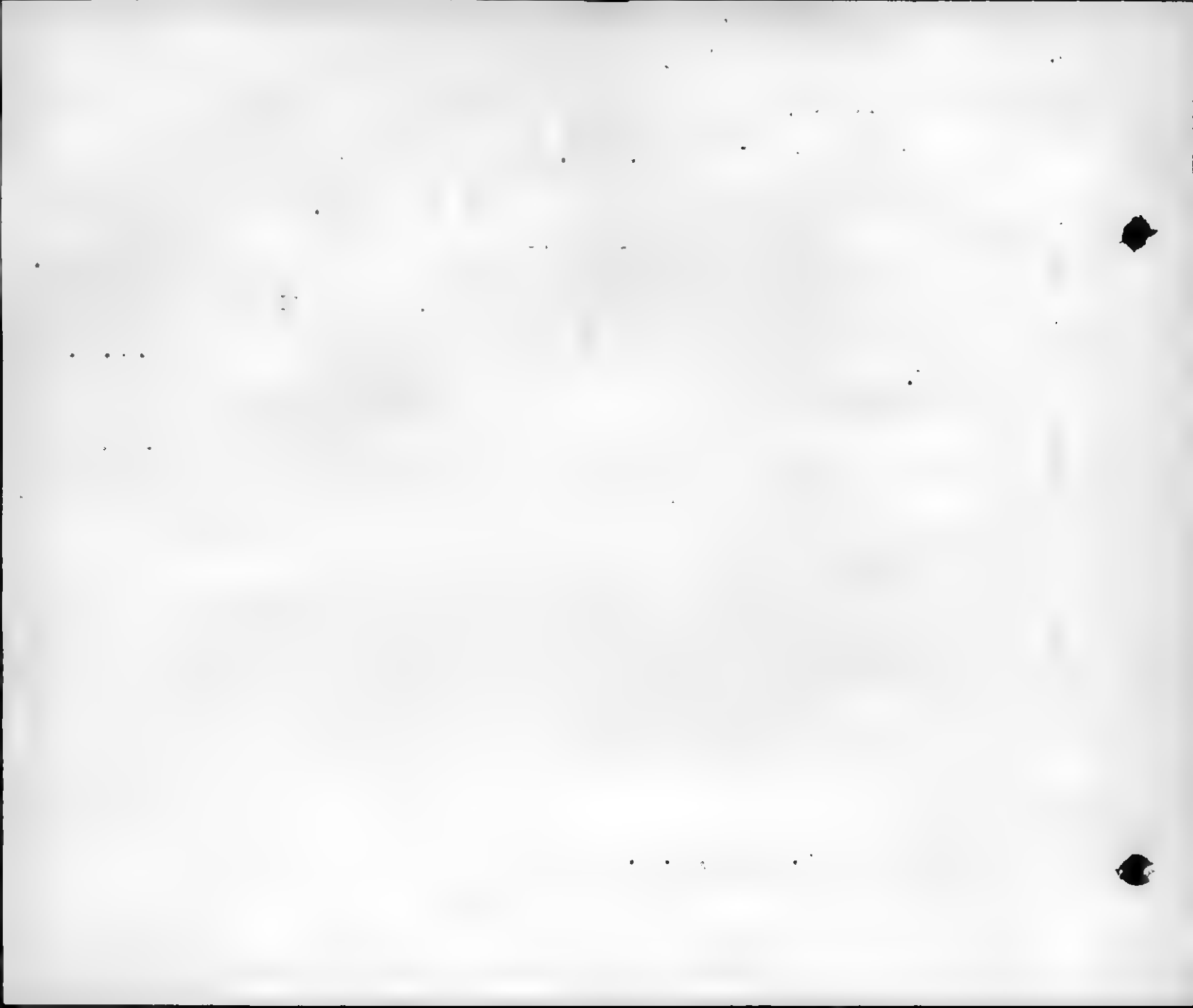
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 14 Yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4948 Battery Lane				d. STREET ADDRESS 4948 Battery Lane			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First NELLIE Middle TREMMELL Last MILLER				4. DATE OF DEATH Month JULY Day 5 , Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1885	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Month 11 Day 19		IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Frank Tremmell				14. MOTHER'S MAIDEN NAME Margaret MacDonald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Fred H. Miller, Jr. Address New York			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH Found dead sitting in chair at home.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Frank J. Broschart</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) FRANK J. BROSCART				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		July 6, 1960	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		22b. DATE THEREOF 7/9/60		22c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery		22d. LOCATION (City, town, or county) (State) Coxsackie, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 7 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. House</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be submitted within 24 hours after death. If any certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Balto.	
c. LENGTH OF STAY IN 1b 7yrs. 3 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home		d. STREET ADDRESS Formerly of 17 Newburg Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Maggie Middle Rosella Last Molesworth		4. DATE OF DEATH Month July Day 26th Year 1960.	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1878
9. AGE (In years last birthday) 81 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 7 Days 23 Hours 40 Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		11b. KIND OF BUSINESS OR INDUSTRY Illinois	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Rufus Molesworth		14. MOTHER'S MAIDEN NAME Elizabeth Wiggins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Asbury Methodist Home-Gaithersburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac vascular accident DUE TO 4-20 Condition, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO 4-20 (c) NAILED FRACTURE OF RT hip		INTERVAL BETWEEN ONSET AND DEATH 7-23-60	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NAILED FRACTURE OF RT hip		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-4 , 19 56 to 7-26 , 19 60 that I last saw the deceased alive on 7-23 , 19 60 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Samuel E. Glover		M.D. 10128 CEDAR LANE KENSINGTON, MD	
PHYSICIAN'S NAME (Type) Sarah E. Glover, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7/29/60	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickson		ADDRESS Balto - 127 Md.	
24a. REC'D BY REGISTRAR Jul 28 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8261

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

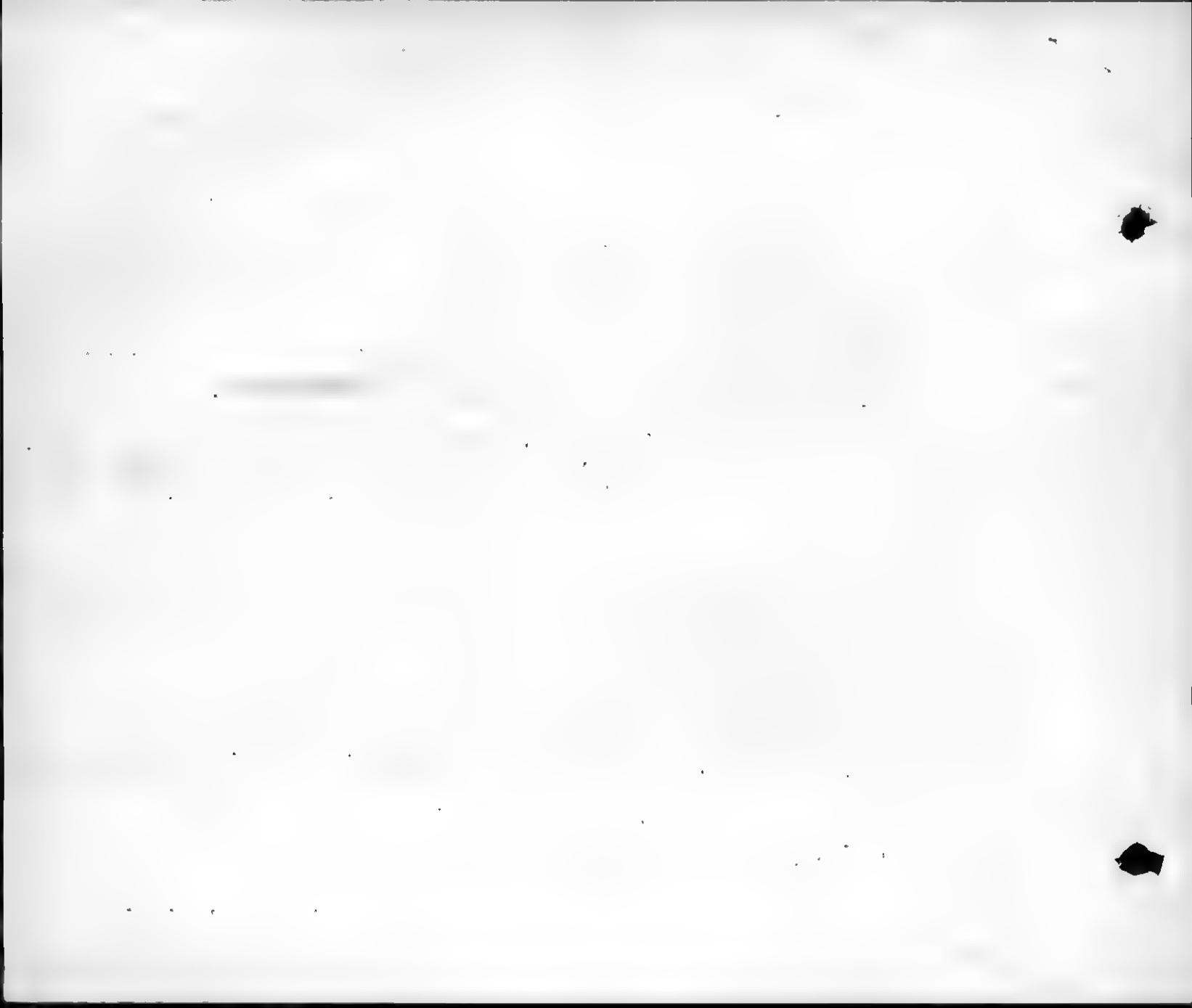
Item 2 Film 6209 8-22-60 et

CERTIFICATE OF DEATH

08212

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland D. C. b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN lb 4 1/2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First M eta Middle W Last Mooney		4. DATE OF DEATH Month July Day 26 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 13, '80
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 89 Days 89 Hours 89 Min. 89	11. IF UNDER 24 HRS Months 89 Days 89 Hours 89 Min. 89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY West Virginia	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Bruce West		14. MOTHER'S MAIDEN NAME Addie (?) (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 710		16. SOCIAL SECURITY NO. none	
17. INFORMANT G. Bruce West, (Nephew)		Address 6105 Welborn Drive, Beth.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Thrombosis of Rt. mid cerebral artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
21. I certify that I attended the deceased from March 19 54 to 25 July 19 60 , that I last saw the deceased alive on 25 July 19 60 , and that death occurred at 1:20 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Bethesda Md DATE SIGNED 26 July 60	
ACTUAL SIGNATURE Herbert M Martyn Jr M.D. 5029		PHYSICIAN'S NAME (Type) HERBERT MARTYN JR	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/60	
22c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE JUL 28 '60		24b. REGISTRAR'S SIGNATURE William S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

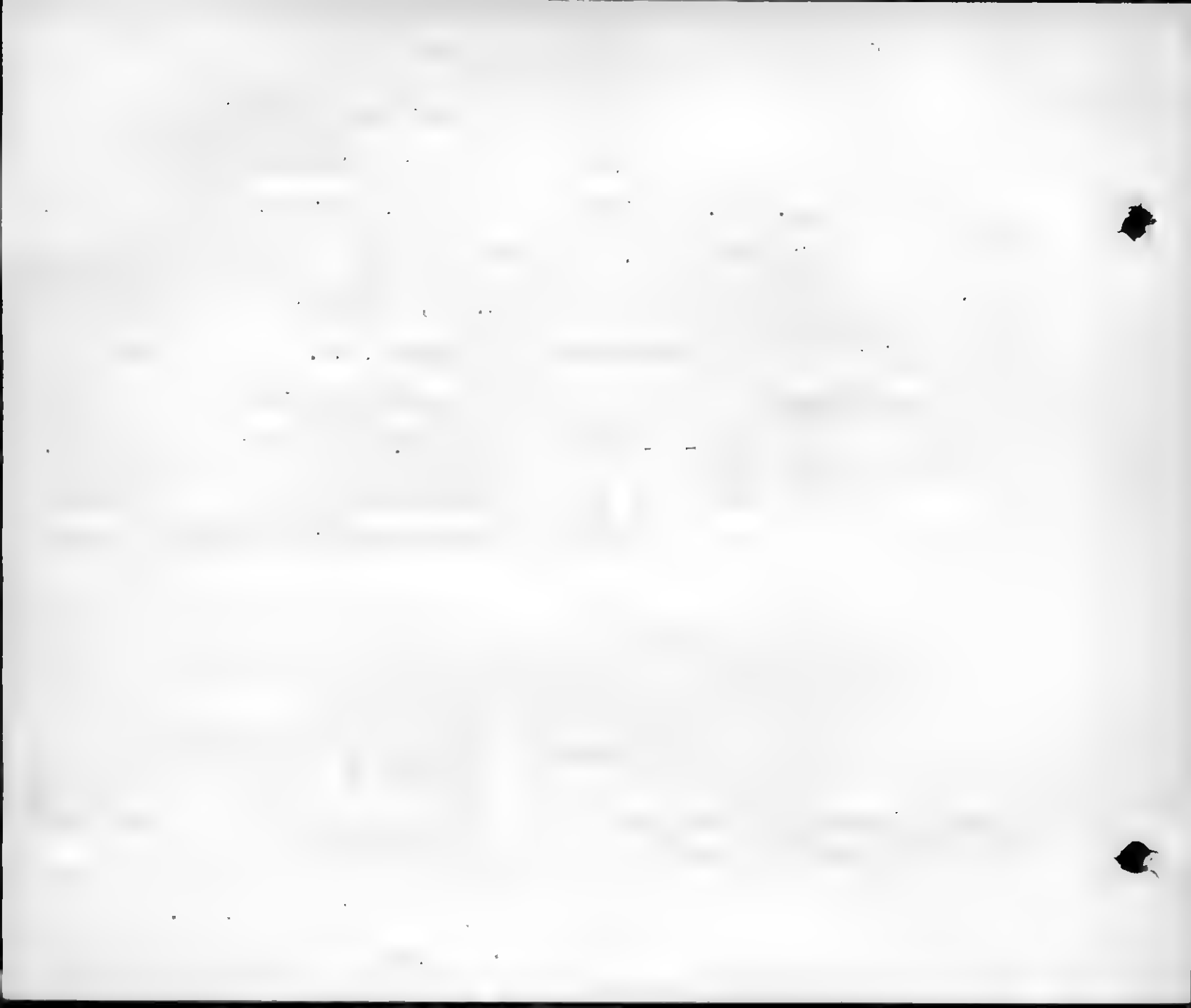
8262

CERTIFICATE OF DEATH

08213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN 1b 3 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery Co. Gen. Hospital				e. STREET ADDRESS RFD # 2, Gaithersburg			
3. NAME OF DECEASED (Type or print) First William Middle F. Last Moore				4. DATE OF DEATH Month July Day 10 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Etchison, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Moore				14. MOTHER'S MAIDEN NAME Lydia Warfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-2414		INFORMANT Address Mrs Pearl E. Moore, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion 120 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) 5 years						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 10, 1942 to July 10, 1960 that I last saw the deceased alive on July 9, 1960 and that death occurred at 2:20 a.m. from the causes and on the date stated above ADDRESS (Street, city or town, state) Damascus, Md. DATE SIGNED 7/11/60 ACTUAL SIGNATURE James P. Kerr M.D. James P. Kerr PHYSICIAN'S NAME (Type) James P. Kerr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/12/60		22c. NAME OF CEMETERY OR CREMATORY Damascus Meth.		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Olin L. Moleworth				24a. REC'D BY REGISTRAR DATE JUL 13 '60		24b. REGISTRAR'S SIGNATURE Charles S. Finner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be completed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9-59

Page 1

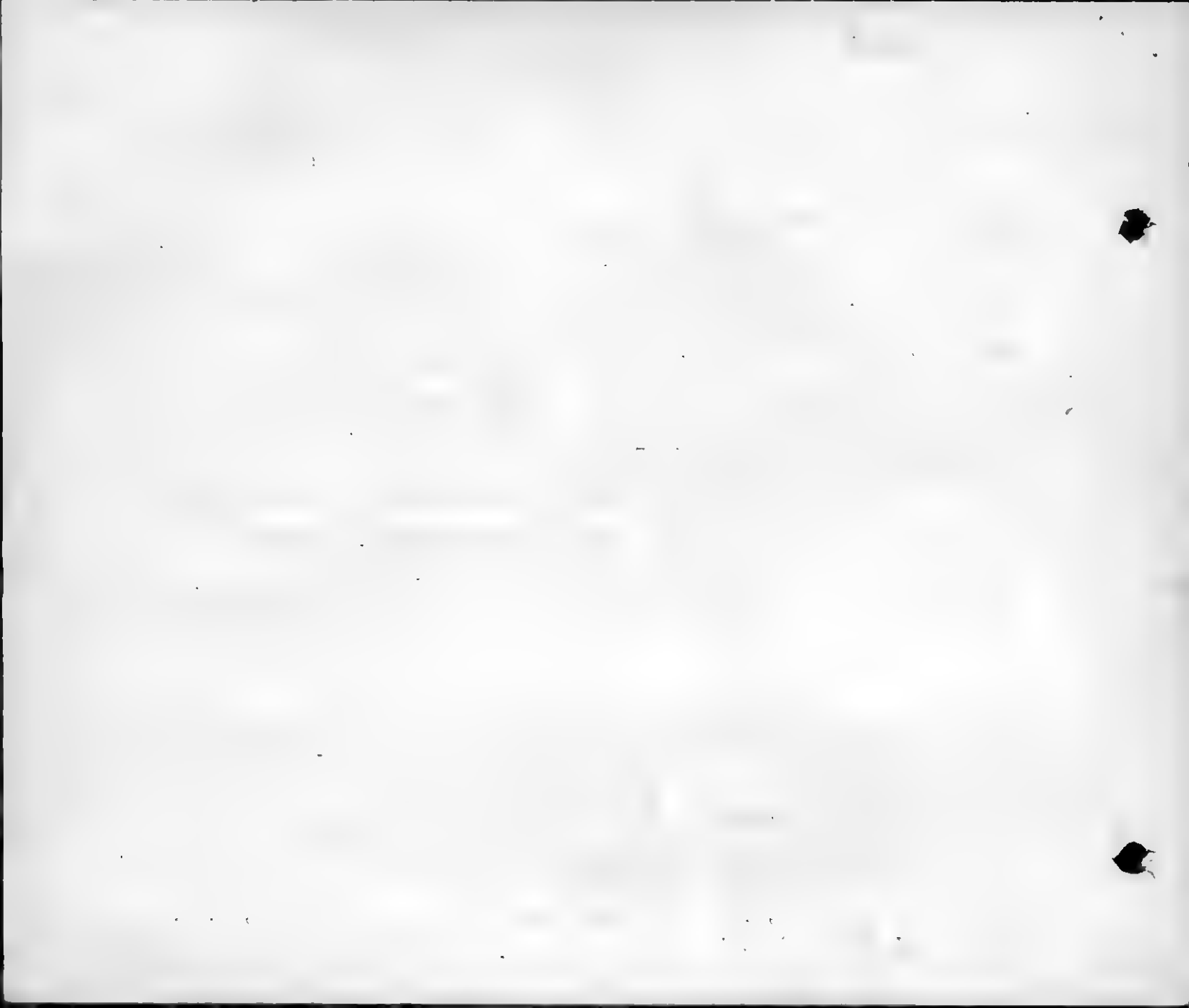
8263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08214

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 412 37th Street, S. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last James Anthony MORALES				4. DATE OF DEATH Month Day Year July 25 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-24-60	
9. AGE (In years last birthday) yrs		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Maryland	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry MORALES				14. MOTHER'S MAIDEN NAME Betty Jo BITTLE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease 773.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c). Prematurity INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) physician attended the deceased from July 24 8:15 PM to July 25 19 60 , that (I) last saw the deceased alive on July 25 19 60 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE Fred W. Grello				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7-26-60	
22c. PHYSICIAN'S NAME (Type) Fred W. GRELLO, LT, MC, USN XXXXXX XXXX XXXX XXXX				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-29-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Pumphrey ADDRESS R. A. Pumphrey Funeral Home, Bethesda, Md.				25a. REC'D BY REGISTRAR JUL 28 1960		25b. REGISTRAR'S SIGNATURE John S. K...	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8125

08216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1009 Merriam Dr.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William Franklin Morris</u>				4. DATE OF DEATH <u>July 25</u> 1960			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 15, 1896</u> 62 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Caretaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apt. house</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen Morris</u>				14. MOTHER'S MAIDEN NAME <u>Frederick Quinton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>231-32-0888</u>		17. INFORMANT <u>Mrs. Morris Silver Spring wife</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Previous Coronary Occlusion</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>3 1/2 hrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1960</u> to <u>July 25, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel W. [Signature]</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-25-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel W. [Signature]</u>				22d. ADDRESS <u>776 Camp [Signature]</u>			
23a. REMOVAL <u>7/26/60</u>				23b. PLACE OF INTERMENT OR CREMATORY <u>MAPLES FUNERAL HOME</u>		23c. LOCATION (City or town) <u>CADEN, N. J.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rabert L. Shoultz</u>				ADDRESS <u>ROCKVILLE, MD.</u>		REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8264

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08217

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE D.C. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 3 wks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Suburban Hosp.		d. STREET ADDRESS 4000 Cathederal Ave.	
3. NAME OF DECEASED (Type or print) Winifred S. Morrow		4. DATE OF DEATH Month July Day 16 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/85
9. AGE (In years and birthday) 75 yrs.		10. UNDER 1 YEAR Months 7 Days 15	
11. IF UNDER 24 HRS. Hours 1 Min 15		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clinton Smith		14. MOTHER'S MAIDEN NAME WEITHEA Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hosp. Record		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ----- (c) -----	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Frank J. Broschart		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Frank J. Broschart		DATE SIGNED 7/16/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 7-18-1960	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Lawler Son 1756 R. Ave. Wash. D.C.		24. REC'D BY REGISTRAR JUL 19 '60	
24b. REGISTRAR'S SIGNATURE Robert S. Kline			



1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 8147
 CERTIFICATE OF DEATH

08218

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) b. STATE <u>Md.</u> b. COUNTY <u>Pri. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>hand over</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven, 517 Albany Ave</u>				d. STREET ADDRESS <u>Rt. 1</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Edmonia</u> Last <u>Nalley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>6</u> Year <u>1960</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 1880</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> M'n <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Joseph Nalley</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Edward Nalley, Rt. Landover Md.</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>434.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>negative heart failure: arterial</u> DUE TO <u>circulation. blood in pulmonary</u> (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>some brain damage</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>			
21. I certify that I attended the deceased from <u>Jan 1, 1960</u> to <u>July 6, 1960</u> that I last saw the deceased alive on <u>July 5, 1960</u> , and that death occurred at <u>2:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>401 West 1st St NW Wash D.C.</u>			
PHYSICIAN'S NAME (Type) <u>Charles H. W. L. H. M.</u>				M.D. <u> </u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 9, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville Md.</u>				ADDRESS <u> </u>			
24a. REC'D BY REGISTRAR DATE <u>JUL 11 '60</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



1
4
8148
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
08210

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Dist. of Columbia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dist. of Columbia</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. and Hosp.</u>				d. STREET ADDRESS <u>2701 14th St., N.W.</u> <u>New Amsterdam Apt. # 516</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Lee</u> Newberry				4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-92</u>	9. AGE (In years last birthday) <u>67</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>	IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank H. Treadwell</u>				14. MOTHER'S MAIDEN NAME <u>Emily Earle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>?</u>		17. INFORMANT <u>Hospital Records --</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1. Intracranial Hemorrhage</u> 331 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic - presenile disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bleeding Cerebral Hemorrhage</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1960</u> to <u>July 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>July 29, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Hare</u>				22b. DATE SIGNED <u>7-30-60</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>	
22d. ADDRESS <u>509 Davis Ave, Takoma Park, Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>7/31/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elian Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Melrose, Florida</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Th S H this Co</u> ADDRESS <u>2901 14th St. N.W. D.C.</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>AUG 2 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Hume</u>	

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may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

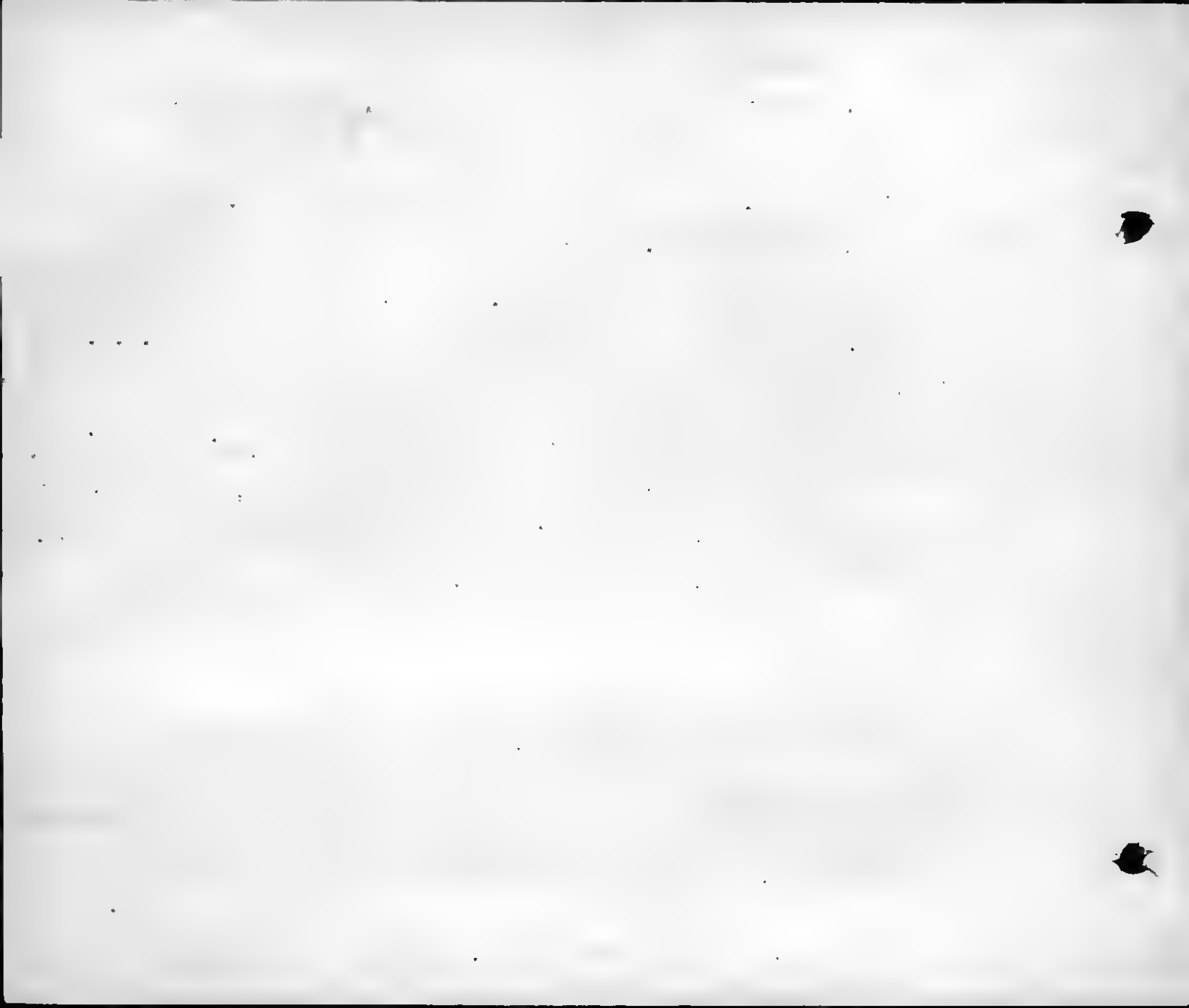
(M)

8126

1
MONTGOMERY STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08220

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 5 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) 2627 Wissman Rd.				e. STREET ADDRESS 2627 Wissman Rd.			
3. NAME OF DECEASED (Type or print) Isabelle B. Nicholson				4. DATE OF DEATH July 4 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7 1893	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during rest of working life even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis Burris				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Reuben Nicholson Address 431 N. Frederick Ave Gaithersburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4-20-0 DUE TO Coronary artery insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior-lateral heart disease with DUE TO chronic heart failure (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH few minutes 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 3 1959 to July 4 1960 that (I) (we) last saw the deceased alive on June 17 1960 and that death occurred at 2:00 PM , from the causes and on the date stated above							
22a. SIGNATURE Adam H. Traum				22b. DATE SIGNED July 6 1960		22c. PHYSICIAN'S NAME (Type) 8237 Georgia Ave, Silver Spring, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 6 1960		23c. NAME OF CEMETERY OR CREMATORY Brookeville		23d. LOCATION (City, town, or county) (State) Brokeville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR AUG 11 '60	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			

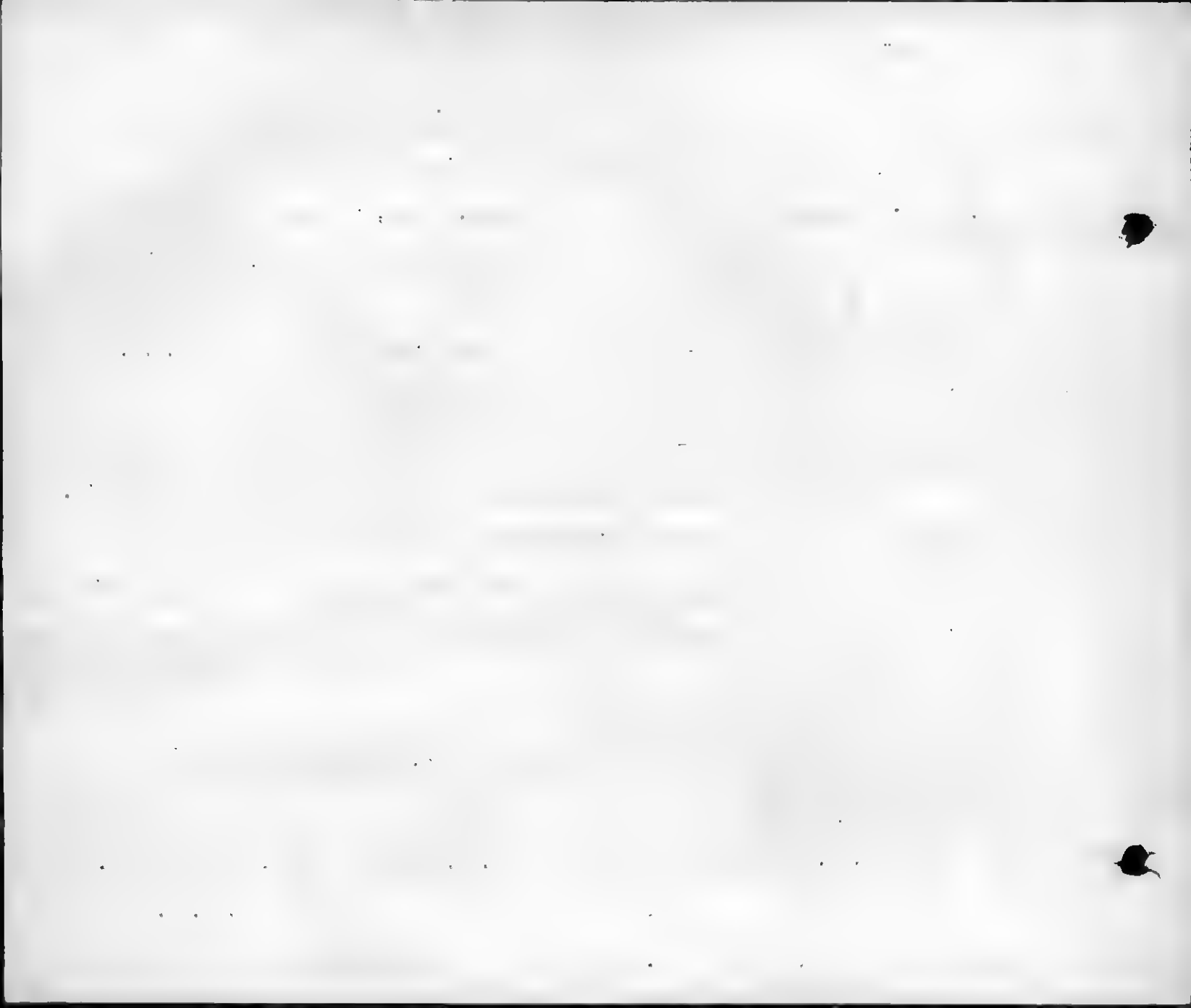


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8265

08222

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Virginia b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Qtrs. 20678, Marine Corps Schools		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bessie Middle Clay Last OAKLEY				4. DATE OF DEATH Month July Day 13 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-96	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David COZART				14. MOTHER'S MAIDEN NAME Kallie SMITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 240-44-1304		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral embolism 4-0-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Auricular fibrillation DUE TO (c) Arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 20 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Squamous cell carcinoma, cervix uteri, stage IV							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) deceased attended the deceased from July 5, 1960 to July 13, 1960 that (I) last saw the deceased alive on July 13, 1960 and that death occurred at 3:30AM M, from the causes and on the date stated above.							
22a. SIGNATURE <i>R. F. Mading</i>				22b. DATE SIGNED 7-13-60		22c. PHYSICIAN'S NAME (Type) R. F. MADING, LT, MC, USN	
22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-16-60		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Boyd Funeral Home</i>				25a. REC'D BY REGISTRAR DATE JUL 19 '60		25b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>	



12
FOR STATE
HEALTH DEPT.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

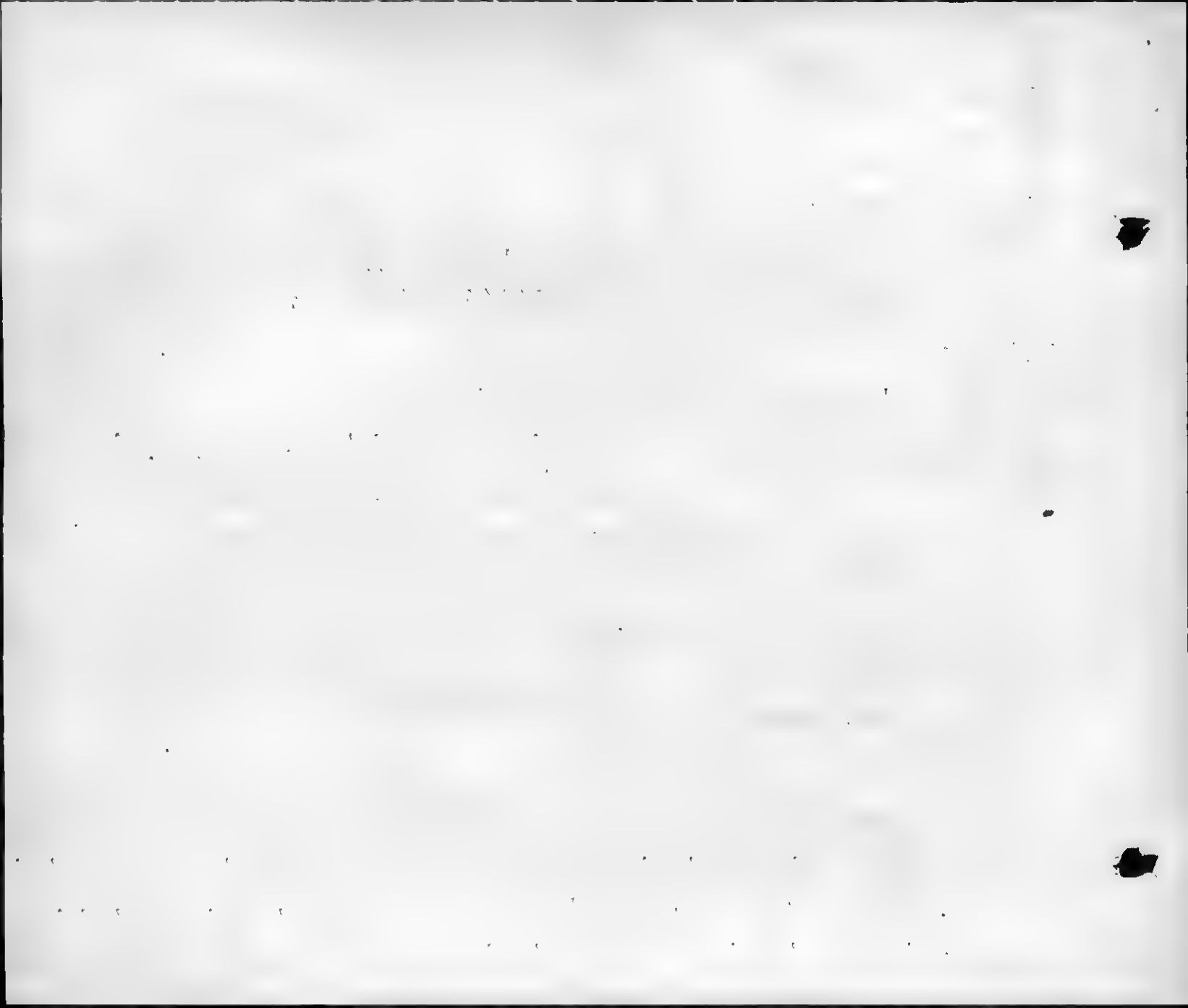
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08222											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. LENGTH OF STAY IN 1b <u>DOA</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash San & Hosp</u>						e. STREET ADDRESS <u>Greencastle Road</u>					
3. NAME OF DECEASED (Type or print) <u>Jack Edward Oden</u>						4. DATE OF DEATH <u>7-21-60</u> Month Day Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-5-37</u> Yrs. Months Days		9. AGE (In years last birthday) <u>23</u> yrs.		10. IF UNDER 1 YEAR <u>IF UNDER 24 HRS.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>					
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>						12. CITIZEN OF WHAT COUNTRY? <u>US</u>					
13. FATHER'S NAME <u>James Ciden</u>						14. MOTHER'S MAIDEN NAME <u>Laura Frazier</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>217-32-492</u>					
17. INFORMANT <u>Margaret Oden-wife-same 2d</u>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Auto accident</u> DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a):											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was driven off onto which left highway & struck tree</u>					
20c. TIME OF INJURY Month, Day, Year <u>7-21-60</u> Hour <u>2:22</u> p.m.						20d. INJURY OCCURRED <u>While at work</u> While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>						20f. (City or town) <u>Laurel</u> (County) <u>Montgomery</u> (State) <u>MD</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>7/25/60</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Derwood Cemetery</u>						22d. LOCATION (City, town, or country) <u>Derwood, Maryland</u> (State)					
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>						ADDRESS <u>Bethesda, Maryland</u>					
24a. REC'D BY REGISTRAR <u>JUL 25 '60</u>						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8127
CERTIFICATE OF DEATH
08223

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
3. NAME OF DECEASED (If not in hospital, give street address) OR INSTITUTION 9603 SUTHERLAND ROAD		d. STREET ADDRESS 9603 SUTHERLAND ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CATHERINE Middle ELLEN Last O'LEARY		4. DATE OF DEATH Month JULY Day 25 Year 1960	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/23
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS O'LEARY		14. MOTHER'S MAIDEN NAME ELLEN CONNOR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs. Bridgett Casey, 9603 Sutherland Rd. Silver Spring, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerosis, Generalized DUE TO (c) Hypertensive Cardiovascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility, Partial deafness, malnutrition	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year July 25, 1960		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1952 to July 25, 1960 that (I) (we) last saw the deceased alive on July 21, 1960 and that death occurred about 3:10 PM from the cause and on the date stated above.			
22a. SIGNATURE George B. Patrick Jr.		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) GEORGE B. PATRICK, JR.		22d. ADDRESS 9221 COLESVILLE ROAD, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		23b. DATE THEREOF 7/28/60	
23c. NAME OF CEMETERY OR CREMATORY St. Michael's New Cemetery		23d. LOCATION (City, town, or county) (State) Westerly, Wash. County, R.I.	
24. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPER, INC. Raymond H. Jaska		25a. REC'D BY REGISTRAR JUL 29 '60	
25b. REGISTRAR'S SIGNATURE Arthur S. Harris			

she has been under my continuous care and has been seen weekly the past 3 weeks. Patrick



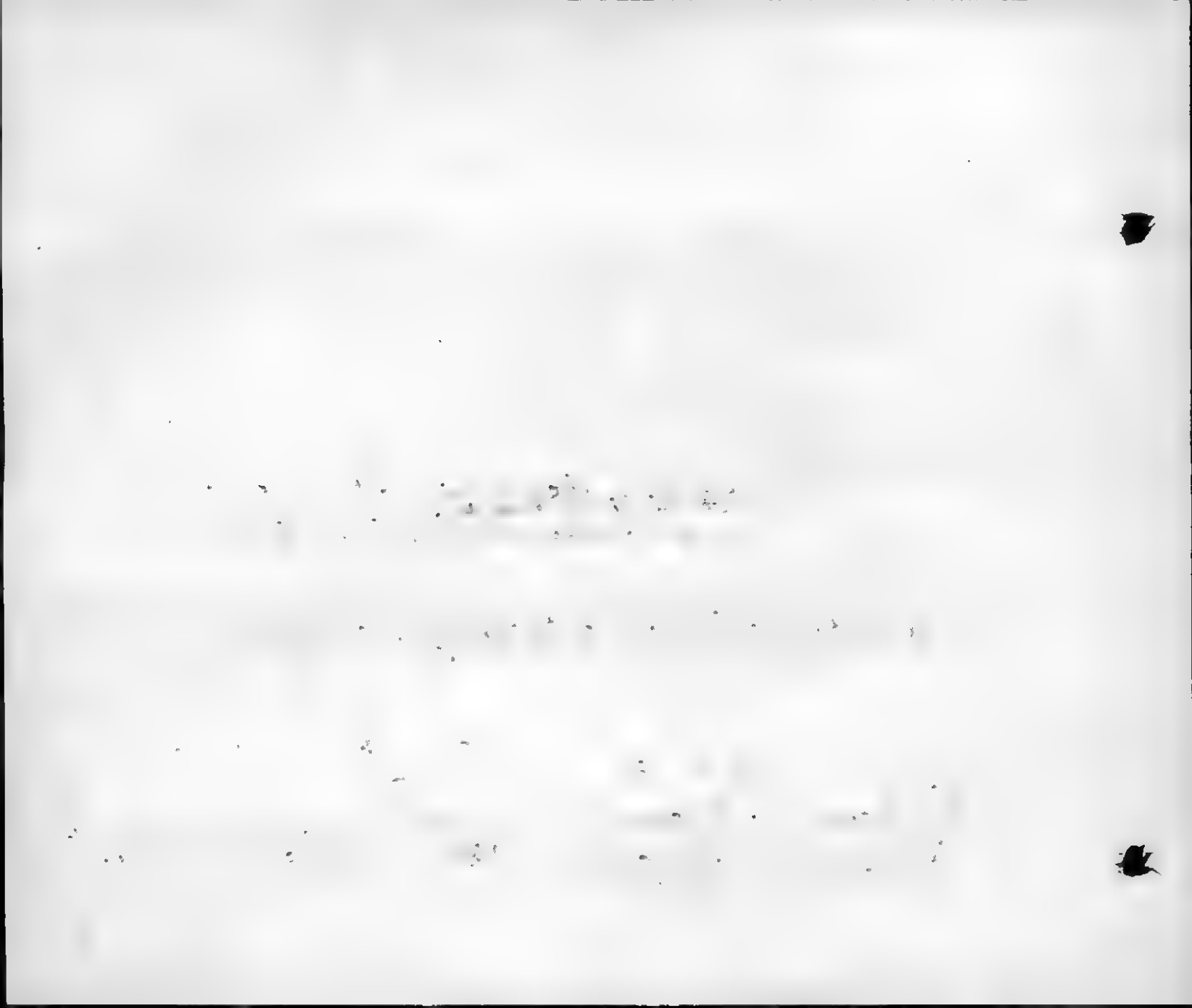
may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have the permit signed by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8174

08224

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>DC.</u> b. COUNTY <u>WASH.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
c. LENGTH OF STAY IN 1b <u>3 WKS.</u>		d. STREET ADDRESS <u>4535-47th ST.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Elizabeth</u> Last <u>Pattison</u>		4. DATE OF DEATH Month <u>7</u> Day <u>14</u> Year <u>1960</u>	
5 SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY & Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Bushong</u>	
14. MOTHER'S MAIDEN NAME <u>Eveline Zirkle</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>577-01-9185</u>		17. INFORMANT <u>Leah & Hightower Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac decompensation and atrial fibrillation</u> DUE TO (b) <u>arteriosclerotic cardiac disease</u> DUE TO (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute yellow atrophy, 6 days.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>about</u> <u>1958</u> to <u>July 14, 1960</u> , that (I) (we) <u>14</u> saw the deceased alive on <u>July 12, 1960</u> , and that death occurred at <u>8:20</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Alban W. Eger</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Alban W. Eger</u>		22d. ADDRESS <u>Washington, D.C.</u> <u>1801 15th ST. N.W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7/16/60</u>	<u>Fort Lincoln Cemetery</u>	<u>Colmar Manor Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>George E. 7 days</u>		25a. REG'D BY REGISTRAR <u>DATE JUL 18 '60</u>	25b. REGISTRAR'S SIGNATURE <u>Charles E. Howard</u>





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8150

08226

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>12 DAYS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>OAK HAVEN CONVALESCENT HOME</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON D.C.</u> d. STREET ADDRESS <u>2008 BRYANT ST N.E. D.C.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emile CHRISTINE Pierson</u>		4. DATE OF DEATH Month Day Year <u>JULY, 16 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 18 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>CAMBRIDGE ILL.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>PETER LARSON</u>	
14. MOTHER'S MAIDEN NAME <u>Ingrid ?</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MRS. DEBA PIERSON</u> Address <u>2008 BRYANT ST NE WASHINGTON D.C.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Longestive heart failure</u> (b) <u>Arteriosclerotic heart</u> (c) <u>disease, Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1960</u> to <u>July 15, 1960</u> , that (I) <u>was</u> last saw the deceased alive on <u>July 14, 1960</u> , and that death occurred at <u>16</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Alfred Brigulio</u> M.D.		22b. ADDRESS <u>2025 Eye St. N.W. Washington, D.C.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Alfred Brigulio, M.D.</u>		22d. DATE SIGNED <u>16 July 1960</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>7/18/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D. C.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			



8267

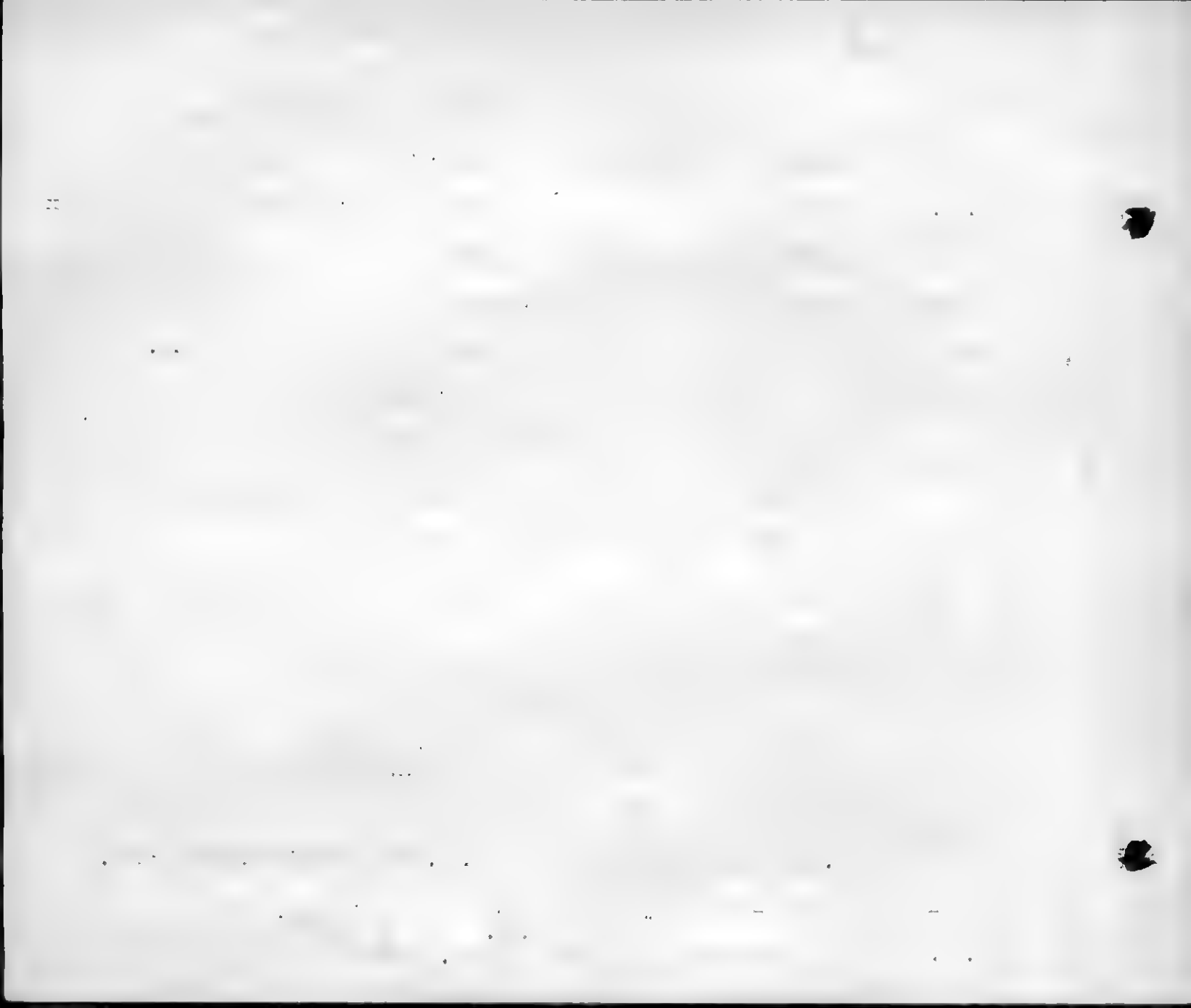
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118227

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				e. STREET ADDRESS 4509 Cheltenham Drive			
3. NAME OF DECEASED (Type or print) First Lillian Middle (n) Last POIKE				4. DATE OF DEATH Month July Day 9 Year 1960			
5. SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-92	
9. AGE (In years last birthday) 67 yrs		10. IF UNDER 1 YEAR Months 7 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0		12. IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY OHIO			
11. BIRTHPLACE (State or foreign country) OHIO				12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME John INGRAM				14. MOTHER'S MAIDEN NAME Laura RUSSELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 111			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMATOSIS DUE TO (b) CARCINOMA, LEFT BREAST DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 7 MONTHS INTERVAL BETWEEN ONSET AND DEATH 2 YEARS							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June 27, 1960 to July 9, 1960 , that (I) (the) last saw the deceased alive on July 9, 1960 , and that death occurred at 1:45 PM , from the causes and on the date stated above.							
22a. SIGNATURE F. S. Caldwell				22b. DATE SIGNED 7-9-60			
22c. PHYSICIAN'S NAME (Type) F. S. CALDWELL LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial-Shipment		7-10-60		Greenlawn Cemetery		Columbus, Ohio	
24. FUNERAL DIRECTOR'S SIGNATURE R. A. PUMPHREY				25a. REC'D BY REGISTRAR JUL 12 '60			
25b. REGISTRAR'S SIGNATURE Arthur S. Moore							

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed within 24 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



8268

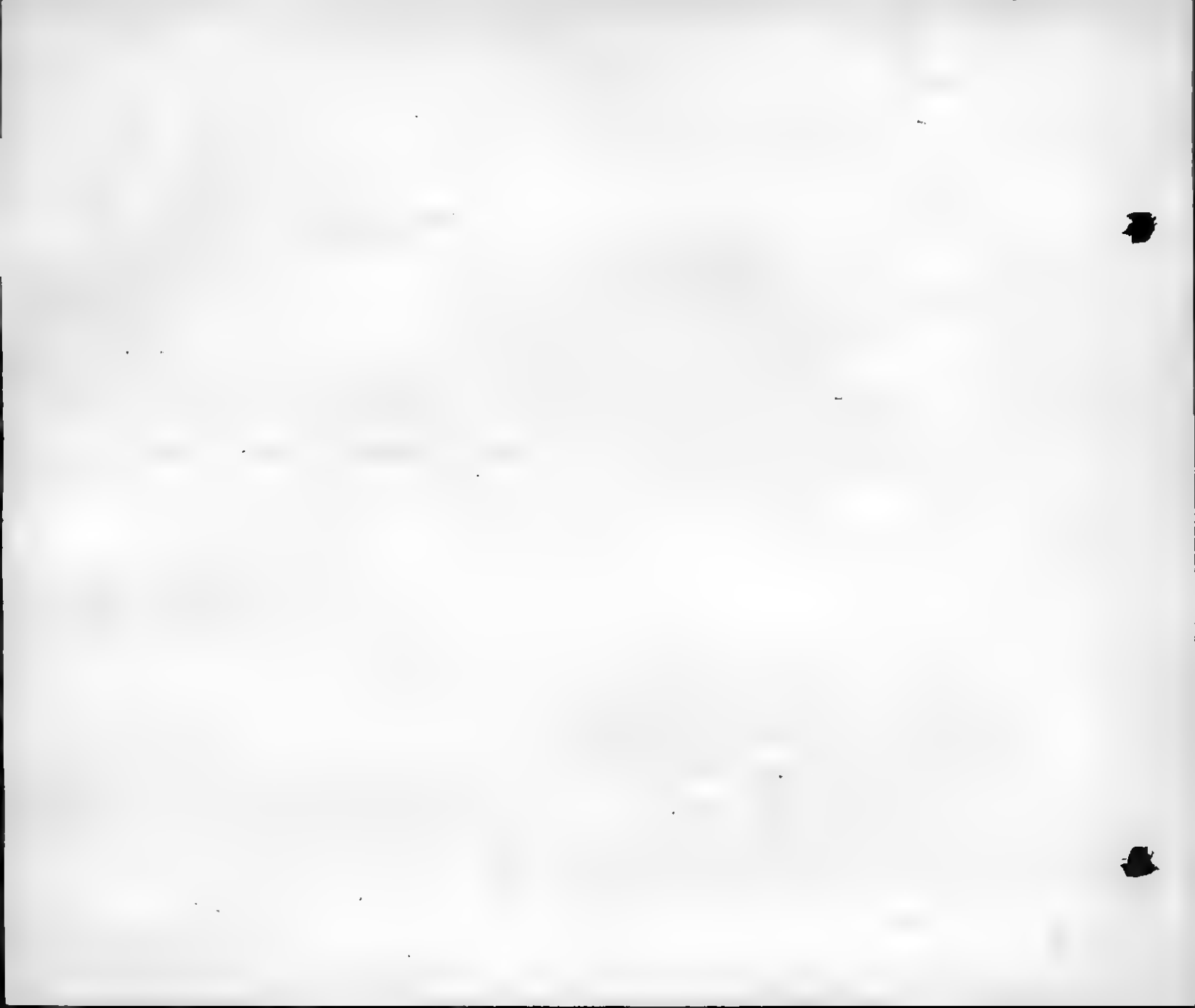
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

18228

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 7 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
		d. STREET ADDRESS Rt. 2, Box 70	
3. NAME OF DECEASED (Type or print) First Middle Last CHERRIE WINIFRED PRATHER		4. DATE OF DEATH Month Day Year JULY 27 19 60	
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/27/60
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME -----		14. MOTHER'S MAIDEN NAME MAUDE LANCASTER PRATHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT HOSPITAL RECORDS, OLNEY, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X Prematurity - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) 2 months - 2 lb 12 g. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27 1960 to July 27 1960 that (I) (we) last saw the deceased alive on July 27 1960 , and that death occurred at 7:00 M, from the causes and on the date stated above			
22a. SIGNATURE William A. Linthicum		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM A. LINTHICUM, M. D.		22d. ADDRESS ROCKVILLE, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/30/60	
23c. NAME OF CEMETERY OR CREMATORY Brooke Grove		23d. LOCATION (City, town, or county) (State) Laytonsville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Robert C. Brannen		25a. REC'D BY REGISTRAR Rockville Md	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE AUG 2 '60	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. -Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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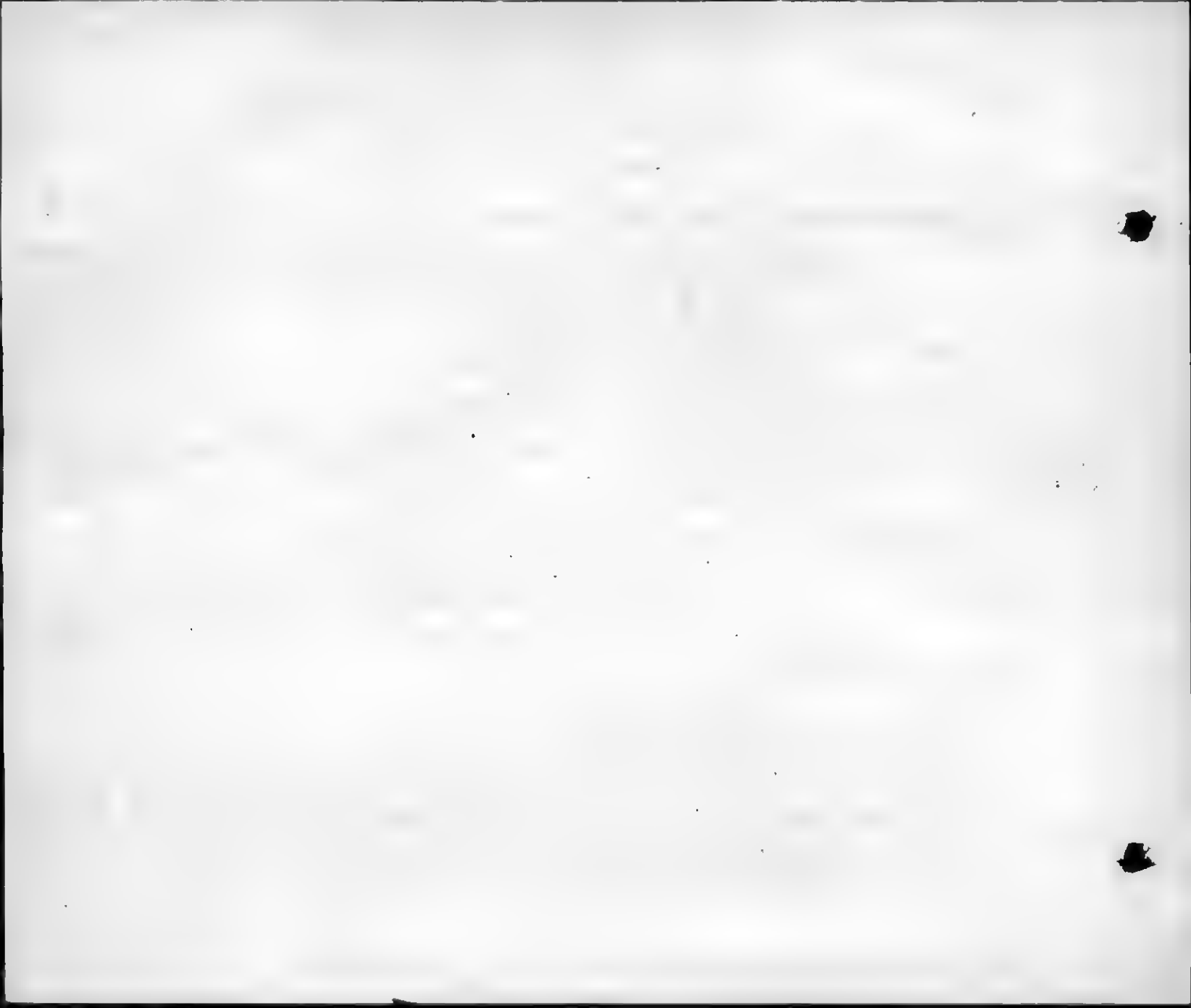


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

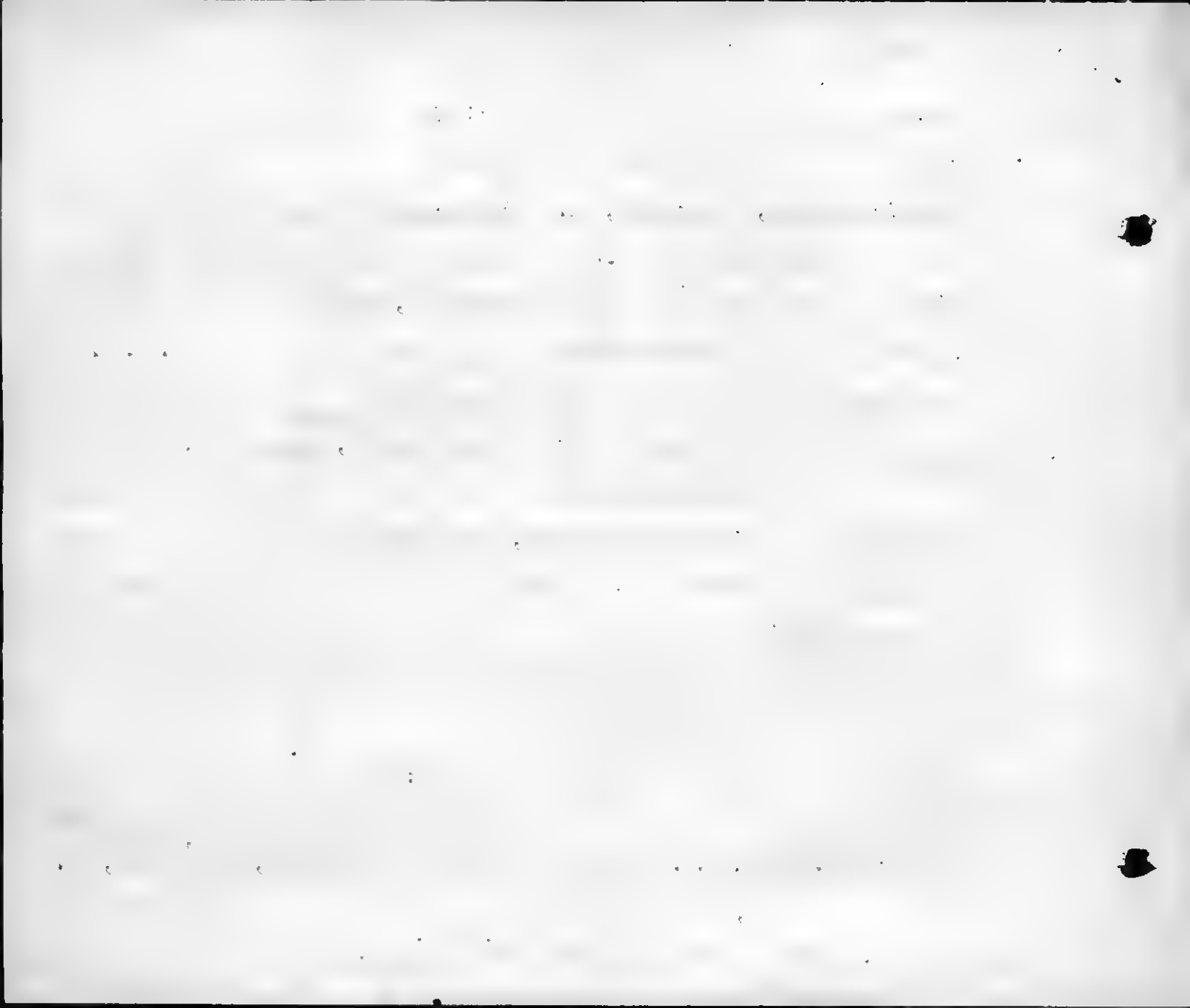
8151

18229

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a STATE <u>District of Columbia</u> b COUNTY <u>✓</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium & Hospital</u>				d. STREET ADDRESS <u>2100 N Street, N.W.</u>			
3 NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>(NMN)</u> Last <u>Price</u>				4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1960</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 23, 1888</u>	9 AGE (In years last birthday) <u>72</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Tarken</u>				14 MOTHER'S MAIDEN NAME <u>Fanny -</u>			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>NONE</u>		17. INFORMANT Address <u>Washington Sanitarium & Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>TRANSLOCATION SMALL INTESTINE</u> DUE TO <u>ASSOC.</u> (c) <u>WITH POST OPERATIVE ADHESIONS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY ABSCESS LEFT UPPER LOBE LUNG</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 25, 1960</u> to <u>JULY 4, 1960</u> , that (I) (we) last saw the deceased alive on <u>JULY 4, 1960</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>James A. Roberts</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED <u>JULY 4, 1960</u>	
22c PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS M.D.</u>				22d ADDRESS <u>8907 Georgia Ave. Silver Spring, Md.</u>			
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>7/6/60</u>		23c NAME OF CEMETERY OR CREMATORY <u>NATL. MEM. PARK</u>		23d LOCATION (City, town, or county) (State) <u>FALLS CHURCH, VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Sheedberg Funeral Home</u> ADDRESS <u>4217-9th ST. S.W.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 7 '60</u>		25b REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	



VR A15 (4)
ISM 9/59



8270

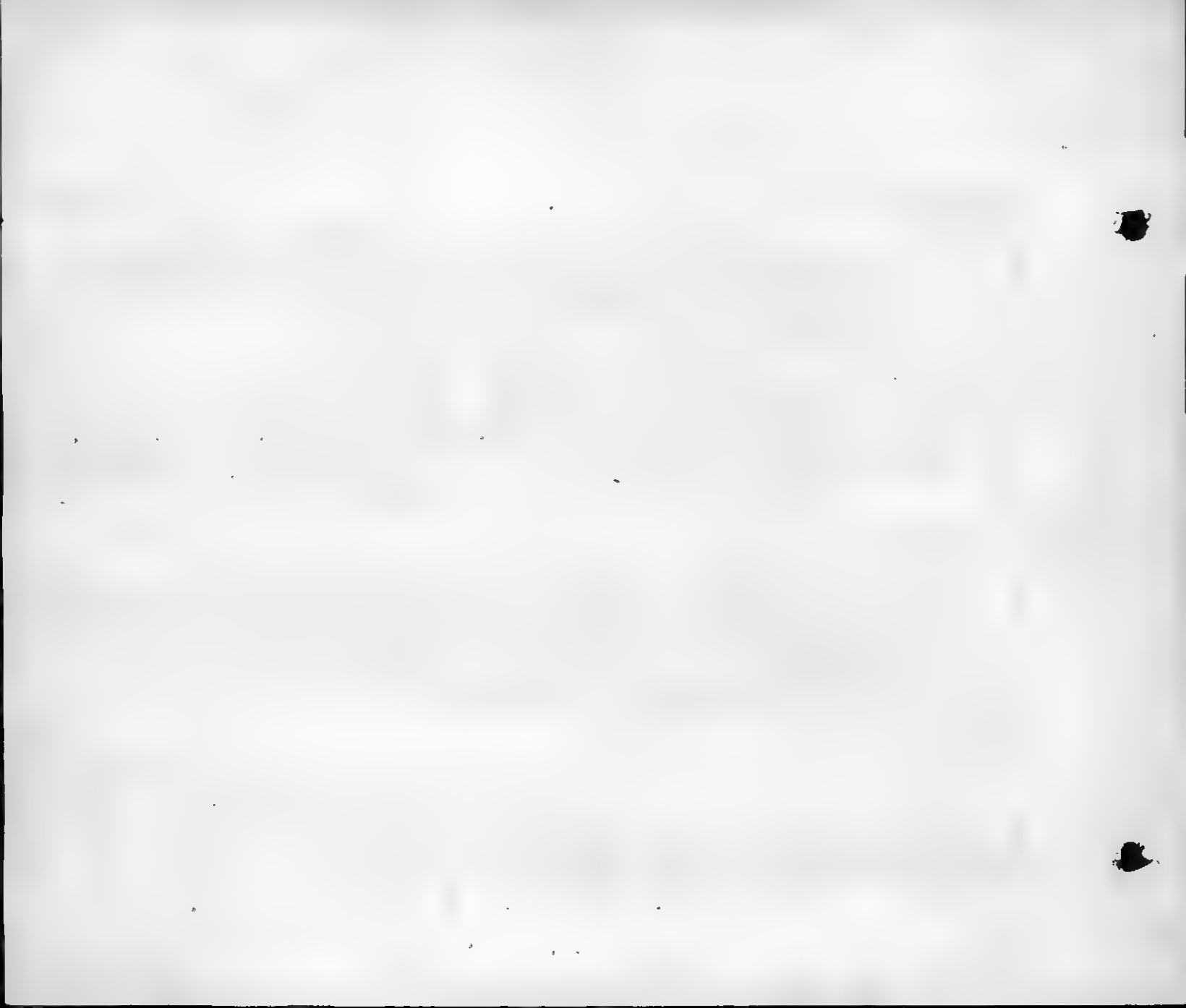
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>20 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Congressional Nursing Home, 9200 Wis. Ave.</i>		d. STREET ADDRESS <i>5071 MacArthur Blvd.</i>	
3. NAME OF DECEASED (Type or print) First <i>Carey</i> Middle <i>E.</i> Last <i>Rector</i>		4. DATE OF DEATH Month <i>7</i> Day <i>12</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/13/1883</i>
9. AGE (In years last birthday) <i>77</i> yrs		IF UNDER 1 YEAR: Months <i>7</i> Days <i>12</i> Hours <i>12</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Owner of a delicatessen + gas station</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Charles H. Rector</i>		14. MOTHER'S MAIDEN NAME <i>Julia Payne</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Early B. Rector</i> Address <i>5411 Cath. Ave., N. W., D.C.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Heart Disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>1 yr.</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6/28</i> 19 <i>60</i> to <i>7/12</i> 19 <i>60</i> that I last saw the deceased alive on <i>7/11/60</i> 19 <i>60</i> and that death occurred at <i>2:00</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Andrew E. Rudnai</i> M.D.		ADDRESS (Street, city or town, state) <i>1120 MacArthur Blvd. Wash. D.C.</i>	
PHYSICIAN'S NAME (Type) <i>ANDREW E. RUDNAI</i>		DATE SIGNED <i>7/12/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7/15/60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Nat. Memorial Pk. Cemt.</i>	22d. LOCATION (City, town, or county) (State) <i>Falls Church, Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph F. Birch</i> ADDRESS <i>3034 M St. N.W., D.C.</i>		24a. REC'D BY REGISTRAR <i>DATE 14 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

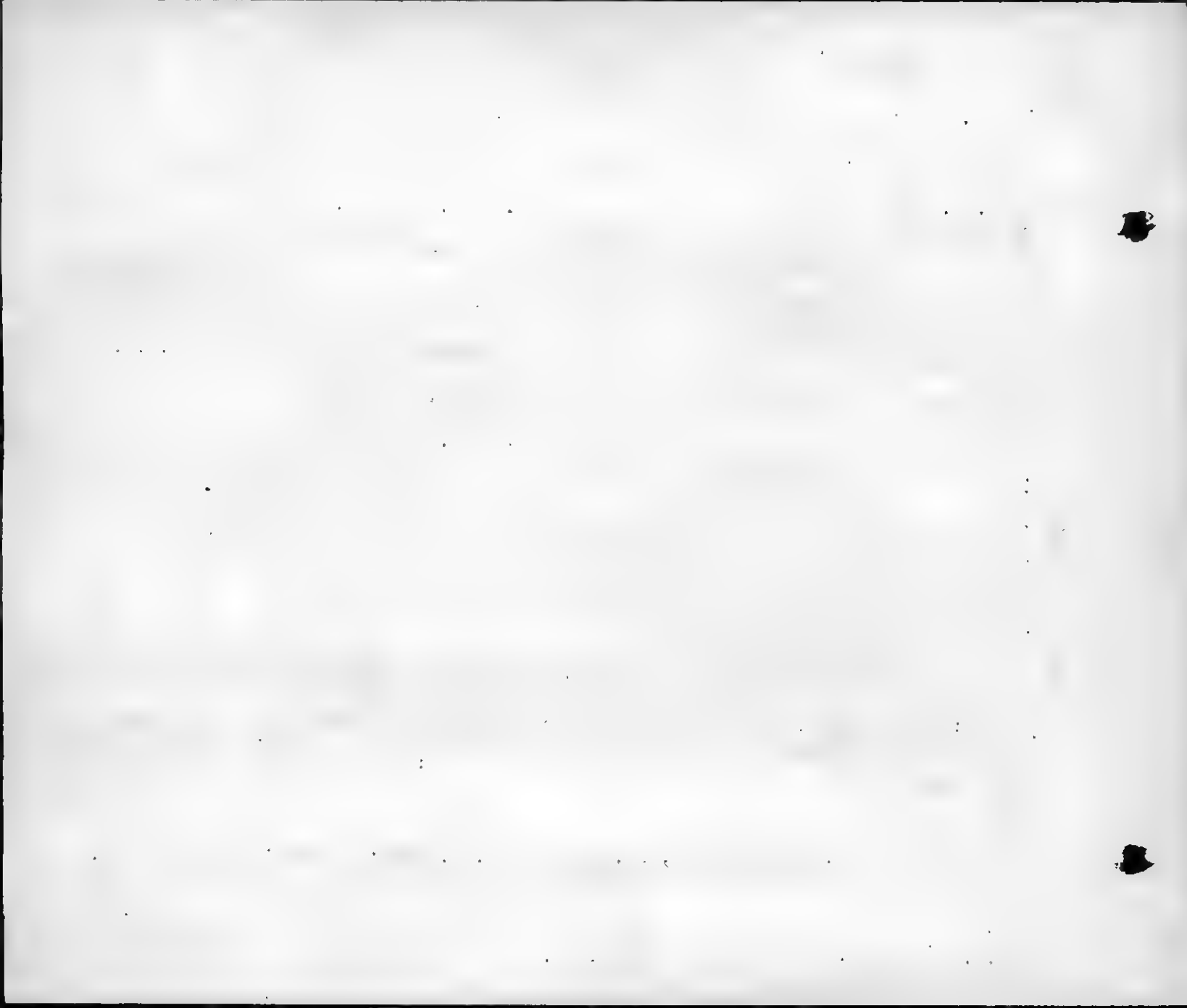
Countersigned by: John G. Ball, M.D., Acting Deputy Medical Examiner

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8271

118232

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Alabama b. COUNTY Mobile c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mobile d. STREET ADDRESS 1955 W. Cardinal Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
3. NAME OF DECEASED (Type or print) Rita Irene RICHARDSON		4. DATE OF DEATH Month July Day 25 Year 1960		5 SEX Female		6. COLOR OR RACE Caucasian		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-28		9 AGE (In years last birthday) 32 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Alabama		12 CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Volon Long				14 MOTHER'S MAIDEN NAME Pearl (unknown)				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16 SOCIAL SECURITY NO - - - - -				17. INFORMANT (H) Lewis A. Richardson, same as #2 above									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Pneumonia + Septicemia DUE TO (b) Extensive 2nd + 3rd Degree Burns Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) - - - - -																		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - - - - -																		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Sitting in car being serviced with butane, explosion and fire						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) occurred.																			
20c. TIME OF INJURY Hour 8:30 p.m. Month July Day 17 Year 1960						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.) Service Station						20f. (City or town) (County) (State) Chickasaw Alabama							
21 I certify that (I) physician attended the deceased from July 19 19 60 , to July 25 19 60 , that (I) last saw the deceased alive on July 25 19 60 , and that death occurred at 1:13 PM , from the causes and on the date stated above.																									
22a. SIGNATURE Guy B. Townsend										22b. DATE SIGNED 7-25-60				22c. PHYSICIAN'S NAME (Type) Guy B. TOWNSEND, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial-Shipment						23b. DATE THEREOF 7/26/60						23c. NAME OF CEMETERY OR CREMATORY Mobile						23d. LOCATION (City, town, or county) (State) Alabama							
24. FUNERAL DIRECTOR'S SIGNATURE R.A. Pumphrey																		25a. REC'D BY REGISTRAR JUL 28 '60				25b. REGISTRAR'S SIGNATURE Curtis S. Thomas			

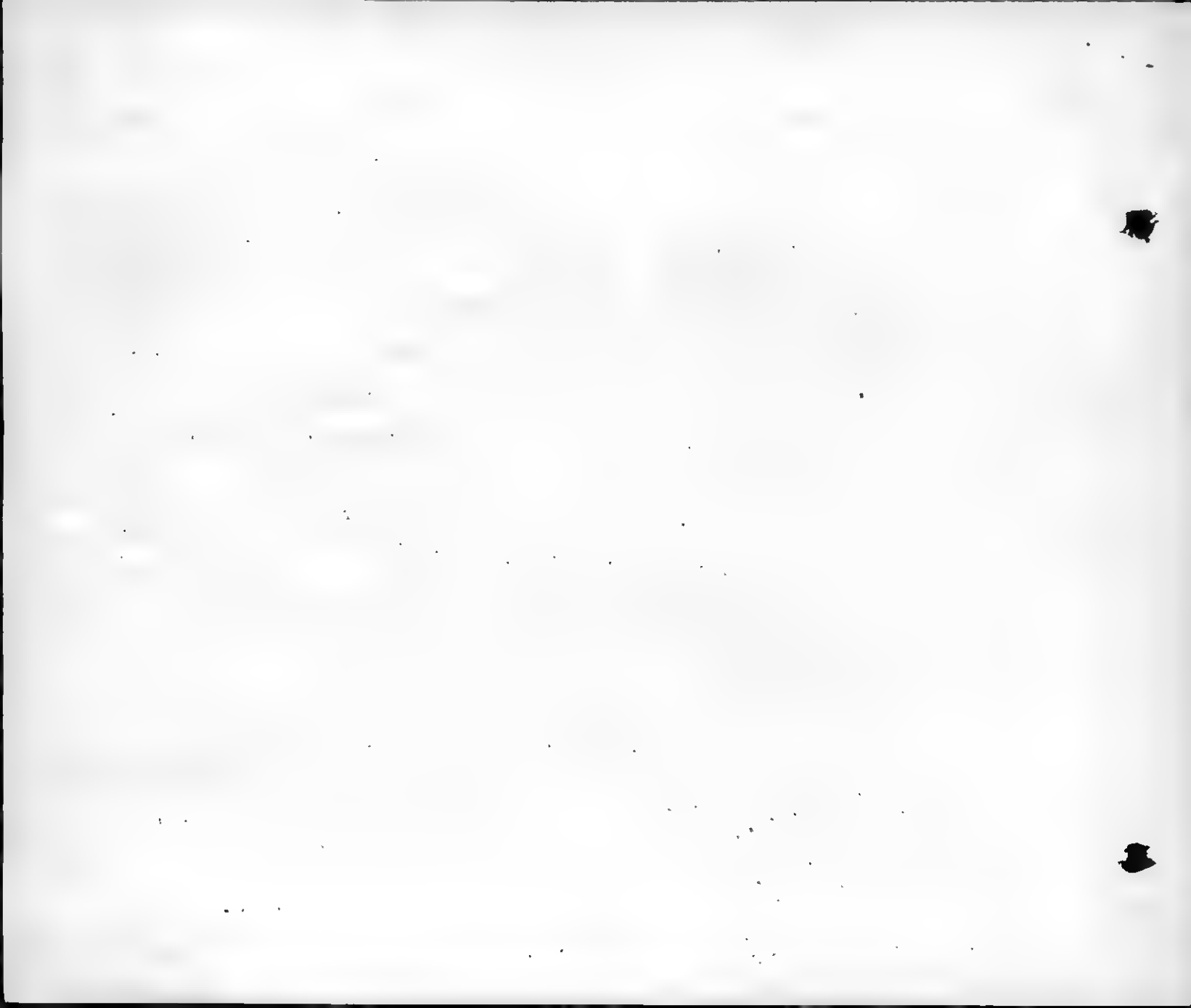


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 41 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the permit papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
8272 Item 8 Willing 207 7-21-60 et											
CERTIFICATE OF DEATH											
Reg. Dist. No. 08253											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						c. LENGTH OF STAY IN 1b 11 Hrs.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suburban						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Hattie Irene Ricketts						4. DATE OF DEATH July 16 19 60					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/25/87 1886		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Edwin Shaw						14. MOTHER'S MAIDEN NAME Mary Sullivan					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None		INFORMANT Hazel Ricketts (Daughter)		Address Above Same as	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pericardial Tamponade DUE TO Rupture, Posterior Wall, Left Ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Myocardial Infarction (b) Myocardial Infarction (c) Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden INTERVAL BETWEEN ONSET AND DEATH Sudden day											
19. WAS A UPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day Year July 13, 1960											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street office bldg, etc.) Potomac, Maryland											
20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from July 13, 1960 to July 16, 1960 , that I last saw the deceased alive on July 16, 1960 , and that death occurred at 10:00 M, from the causes and on the date stated above.											
22. ADDRESS (Street, city or town, state) Bethesda, Md.											
DATE SIGNED July 19, 1960											
ACTUAL SIGNATURE W.T. Joyce M.D.											
PHYSICIAN'S NAME (Type) W.T. Joyce											
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial											
22b. DATE THEREOF 7/20/60											
22c. NAME OF CEMETERY OR CREMATORY Potomac Meth. Ch. Cem.											
22d. LOCATION (City, town or county) (State) Potomac, Maryland											
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler											
ADDRESS 1331 E. Montg. Ave. Rockville, Maryland											
24a. REC'D BY REGISTRAR DATE Jul 19 '60											
24b. REGISTRAR'S SIGNATURE Arthur S. Hume											



1
FOR STATE HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

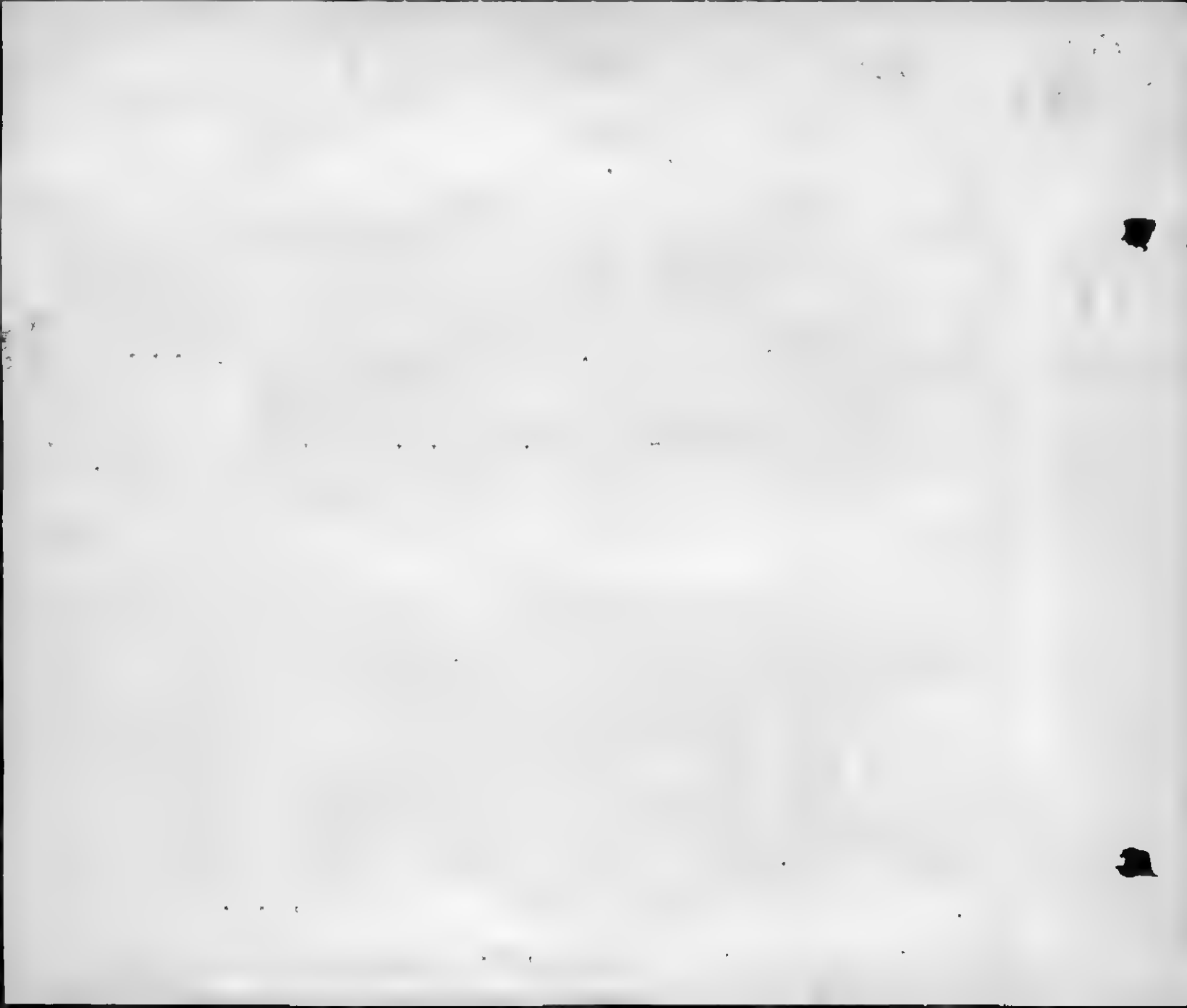
8128

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

108254

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8666 PINEY BRANCH ROAD				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING d. STREET ADDRESS 8666 PINEY BRANCH ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KENNETH FELTON RIDLEY First Middle Last				4. DATE OF DEATH JULY 23 19 60 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/21/05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aeronautical engineer		10b. KIND OF BUSINESS OR INDUSTRY Vitro Corp.		11. BIRTHPLACE (State or foreign country) California		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE RIDLEY				14. MOTHER'S MAIDEN NAME KATHLEEN BRANDT BRANDT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 554-10-2865		17. INFORMANT Mrs. Edna R. F. Ridley, 8666 Piney Branch Rd. Silver Spring, Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertensive Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min. 10 yr. +							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) JOHN G. BALL				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 7/23/60 DATE SIGNED			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) TRANS. & BURIAL		22b. DATE THEREOF 7/26/60		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		22d. LOCATION (City, town, or country) (State) Trenton, N. J.	
23. FUNERAL DIRECTOR WARNER E. PUMPHREY, INC. Raymond E. Zutter				ADDRESS SILVER SPRING, MD.		24a. REC'D BY REGISTRAR JUL 26 1960	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

(M)

1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08235

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>9 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Seven Locks Rd.</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>Seven Locks Rd.</u>		
3. NAME OF DECEASED (Type or print) <u>Howard Robinson</u>			4. DATE OF DEATH <u>July 16 1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 9, 1913</u>		9. AGE (in years, if under 1 year, last birthday) <u>46</u> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labour</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>DC</u>
13. FATHER'S NAME <u>Kane Robinson</u>			14. MOTHER'S MAIDEN NAME <u>Violet</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Brooklyn R. Johnson</u> Address <u>Stem 2</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>981 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration of liver & Abdominal Aorta</u> DUE TO (c) <u>Bullet wound</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported shot with 22 cal rifle by his sister</u>		
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 7-16 1960</u>			20d. INJURY OCCURRED 21. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home Bethesda Montgomery MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>7/21/60</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>County Home</u>			22d. LOCATION (city, town, or country) <u>Rockville, Md.</u>		
23. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>JUL 25 '60</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>		

DATE SIGNED

7-18-60



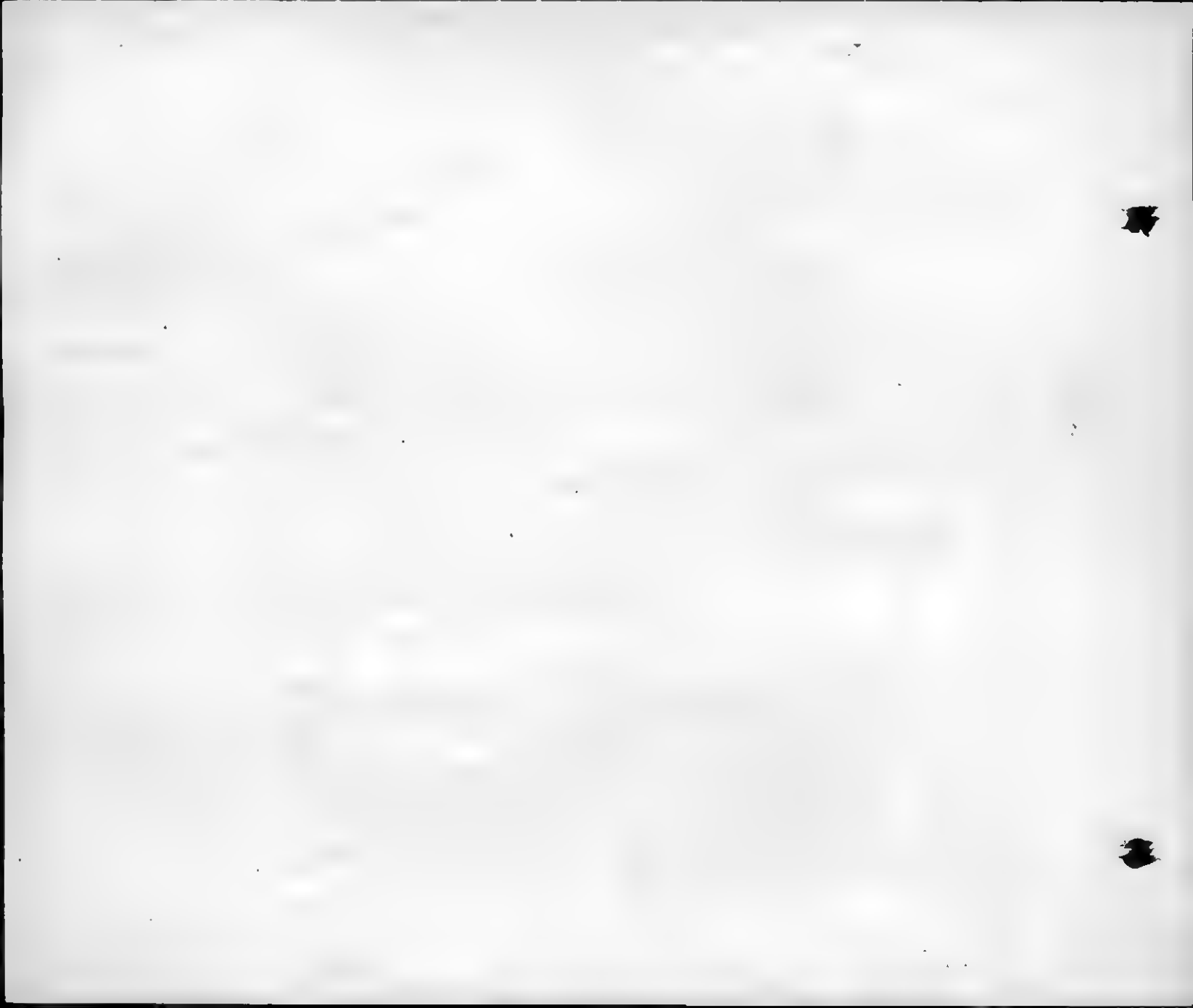
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please forward the carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
8152
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08236

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Virginia</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SAKOMA PARK</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waynesboro</i>	
c. LENGTH OF STAY IN 1b <i>Amos 15 days</i>		d. STREET ADDRESS <i>216 So.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Ave. Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Julia</i> Middle <i>ANNA</i> Last <i>SANDRIDGE</i>		4. DATE OF DEATH Month <i>7</i> Day <i>15</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-29-85</i>
9. AGE (In years lost birthday) <i>75</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>America</i>	
13. FATHER'S NAME <i>Robert Marshall</i>		14. MOTHER'S MAIDEN NAME <i>Lucille Via</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Pt Hospital Record</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Emphysema Respiratory failure</i> DUE TO <i>Brain tumor.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>5/6</i> <i>1960</i> to <i>7/15</i> <i>1960</i> , that (I) (we) last saw the deceased alive on <i>7/15</i> <i>1960</i> , and that death occurred at <i>3:45 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Aldo Vacca</i>		22b. DATE SIGNED <i>7/15/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Aldo Vacca</i>		22d. ADDRESS <i>1429 University Blvd. W. SSF</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>July 18, 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Horeb Ch. Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Augusta Co. VA.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kline</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kline</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		25c. DATE <i>JUL 21 '60</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

8153

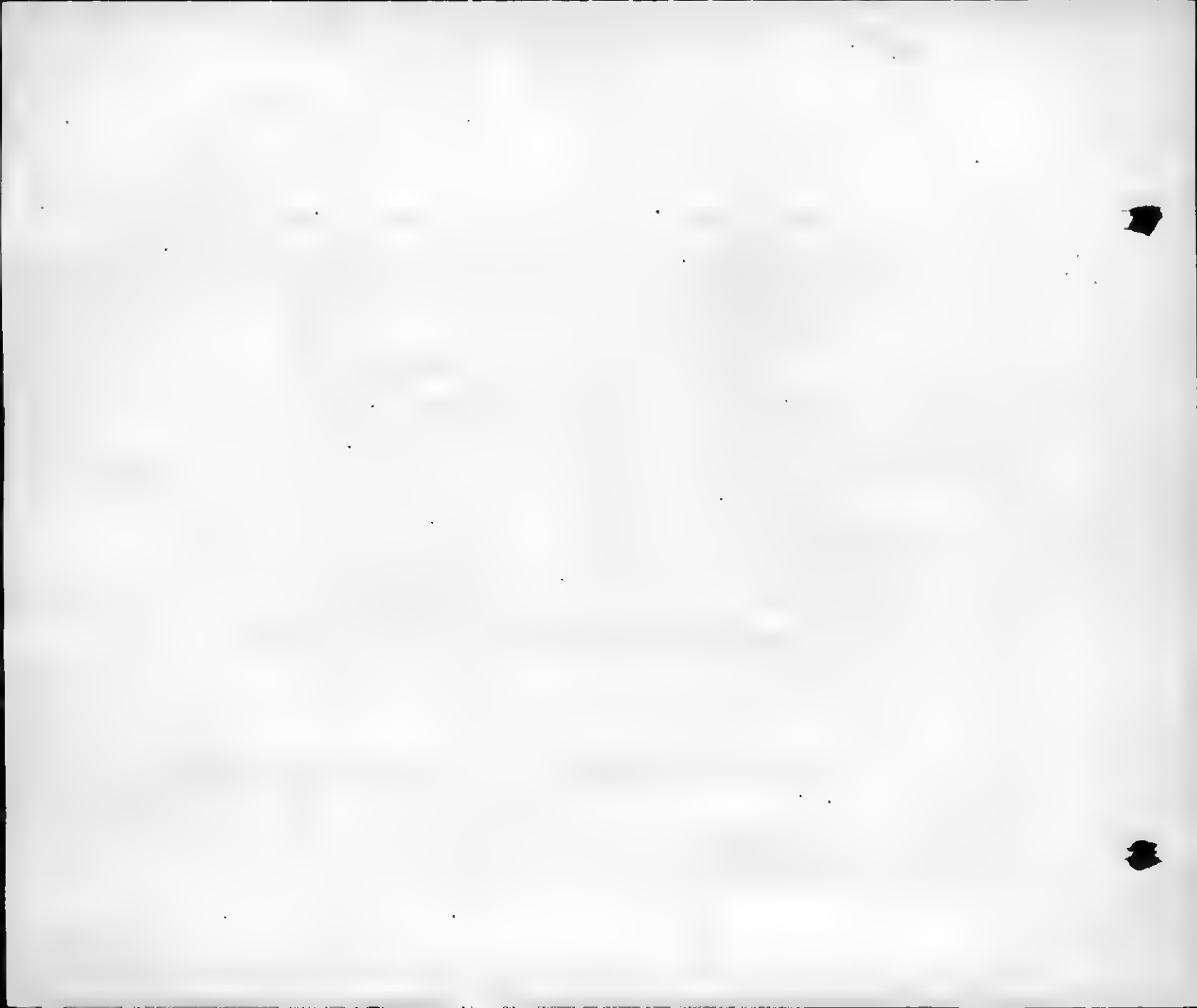
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 2 filed 6-27-60

08237

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>M.D.C.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothy Barbara Sanford</u>		4. DATE OF DEATH Month Day Year <u>July 5 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-84</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>D.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank Hoffman</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Nickton</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>518-30-566</u>		17. INFORMANT Address <u>Hospital Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic kidney disease.</u> DUE TO (c) <u>Cerebrovascular disease.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Uncomplicated Perineal Peritonitis - Intestinal Obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 27 1960</u> to <u>July 5 1960</u> that (I) (we) last saw the deceased alive on <u>July 5 1960</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Lyle Williams</u>		22b. DATE SIGNED <u>July 5 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lyle Williams</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>7/8/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. ...</u>		25a. REC'D BY REGISTRAR <u>Jul 11 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capstan papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8274 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08238

CERTIFICATE OF DEATH

Reg 140

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Ill. b. COUNTY St. Clair	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Rural Rockville Md 14 3 Mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East St Louis Ill.	
d. NAME OF HOSPITAL (If not in hospital, give street address) Waverly Sanitarium 2502		d. STREET ADDRESS 529 Washington Pl.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mrs Florence First Middle Last Schilb		4. DATE OF DEATH Month 7 Day 25 Year 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-6-1872
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Mo.	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Cables		14. MOTHER'S MAIDEN NAME Sarah Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
INFORMANT Louis P. Allwine Address 1141 Rockville Pike Rockville Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-respiratory failure 440X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) lobar pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 12 hrs. 5 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 April , 19 59 , to 25 July , 19 60 ; that I last saw the deceased alive on 25 July , 19 60 , and that death occurred at 10 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 7801 Norfolk Ave. DATE SIGNED 25 July 60 ACTUAL SIGNATURE John M. Wyman M.D. PHYSICIAN'S NAME (Type) John M. Wyman M.D. Bethesda Md			
22a. BURIAL, CREMATION REMOVAL (Specify) Bur-Transit 7/29/60		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Bellefonte, Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 27 '60	
		24b. REGISTRAR'S SIGNATURE Carlton J. K...	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

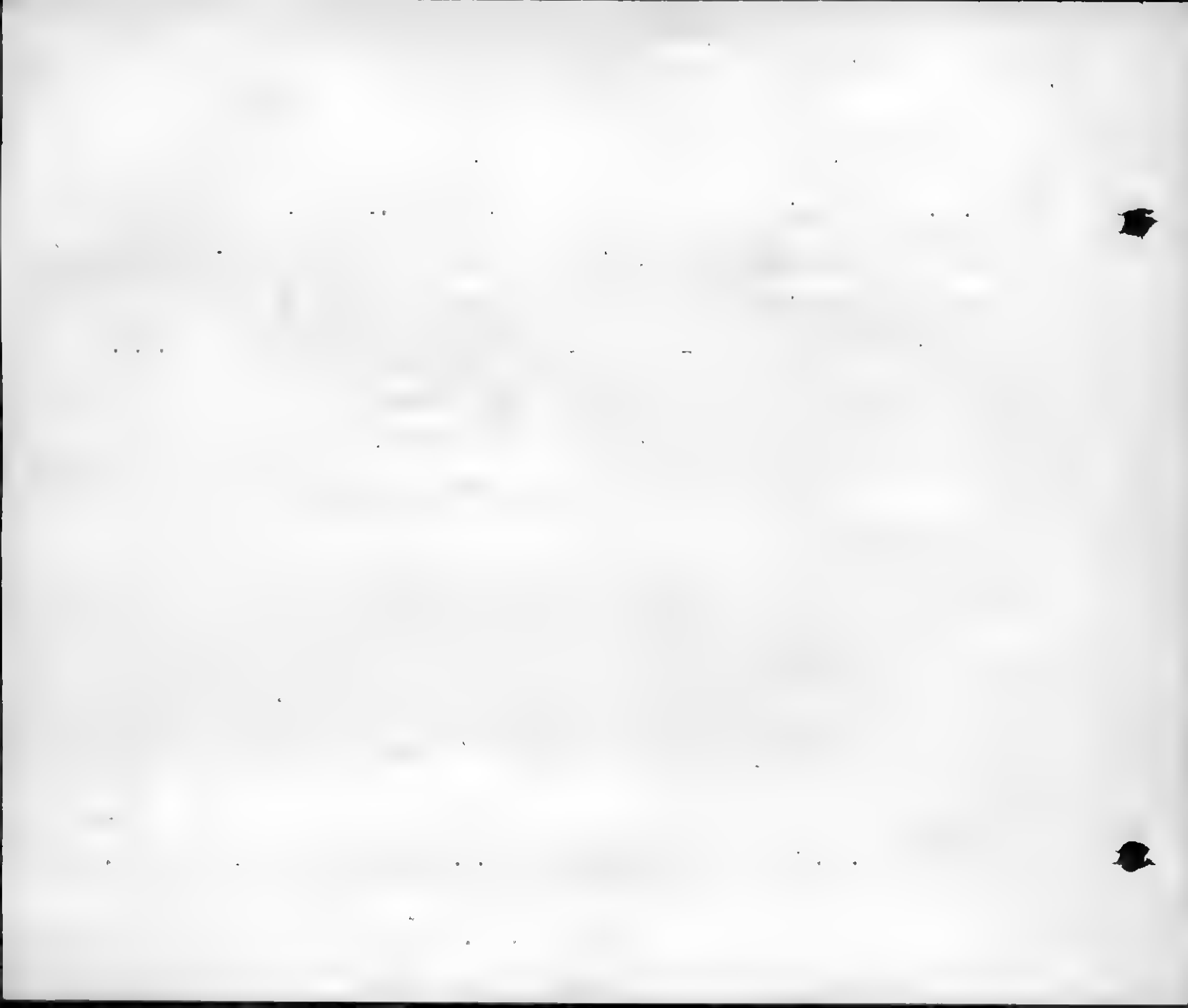
VR A15 (4)
15M 9/59

8275
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08239

1 PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		d. STREET ADDRESS Margaret Rd., RFD 8, Box 182					
3. NAME OF DECEASED (Type or print) First Alma		Middle Sophia		Last SCOTT		4. DATE OF DEATH Month July	
5 SEX Female		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-25-97	
9 AGE (In years last birthday) 62 yrs		IF UNDER 1 YEAR Months 62		IF UNDER 24 HRS. Days 15		Year 19 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John KIRKHAM		14. MOTHER'S MAIDEN NAME Mary Bletzer					
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-18-2623		17 INFORMANT (S) George Scott, same as #3 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) Carcinoma of breast - metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from July 14 19 60 to July 15 19 60 , that (I) (we) last saw the deceased alive on July 15 19 60 and that death occurred at 2:05 PM from the causes and on the date stated above.							
22a SIGNATURE E. J. Rupnik		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b DATE SIGNED 7-15-60			
22c. PHYSICIAN'S NAME (Type) E. J. RUPNIK, CDR, MC, USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Md.					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 20 July 1960		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetary		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lilly and Zeiler Funeral Home		ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR Wolfe & Eastern		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	
DATE Jul 19 '60							

Avenue



FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, it should be executed by the Medical Examiner's Office. Pages 1, 2, and 3 to be retained for your files. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MD 8166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08240

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Freedom d. STREET ADDRESS			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg c. LENGTH OF STAY IN 1b 7 yrs.				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Asbury Methodist Home			
3. NAME OF DECEASED (Type or print) Alice Bennett Selby				4. DATE OF DEATH July 31, 1960 Month July Day 31 Year 1960			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/12/1873 last birthday	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bennett				14. MOTHER'S MAIDEN NAME Eliza Roberts			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None records				16. SOCIAL SECURITY NO. None records			
17. INFORMATION				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 153.9 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of upper intestinal tract (c) 1 yr cause last, (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Frank J. Broschart M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Frank J. Broschart				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED Aug. 1, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 8-3-60		22c. NAME OF CEMETERY OR CREMATORY Freedom Church		22d. LOCATION (City, town, or country) (State) Gaithersburg Md	
23. FUNERAL DIRECTOR Emmett B. Gaither, Gaithersburg Md				24a. REC'D BY REGISTRAR Aug 3 '60			
				24b. REGISTRAR'S SIGNATURE Arthur L. Kneiss			

MEDICAL CERTIFICATION



may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

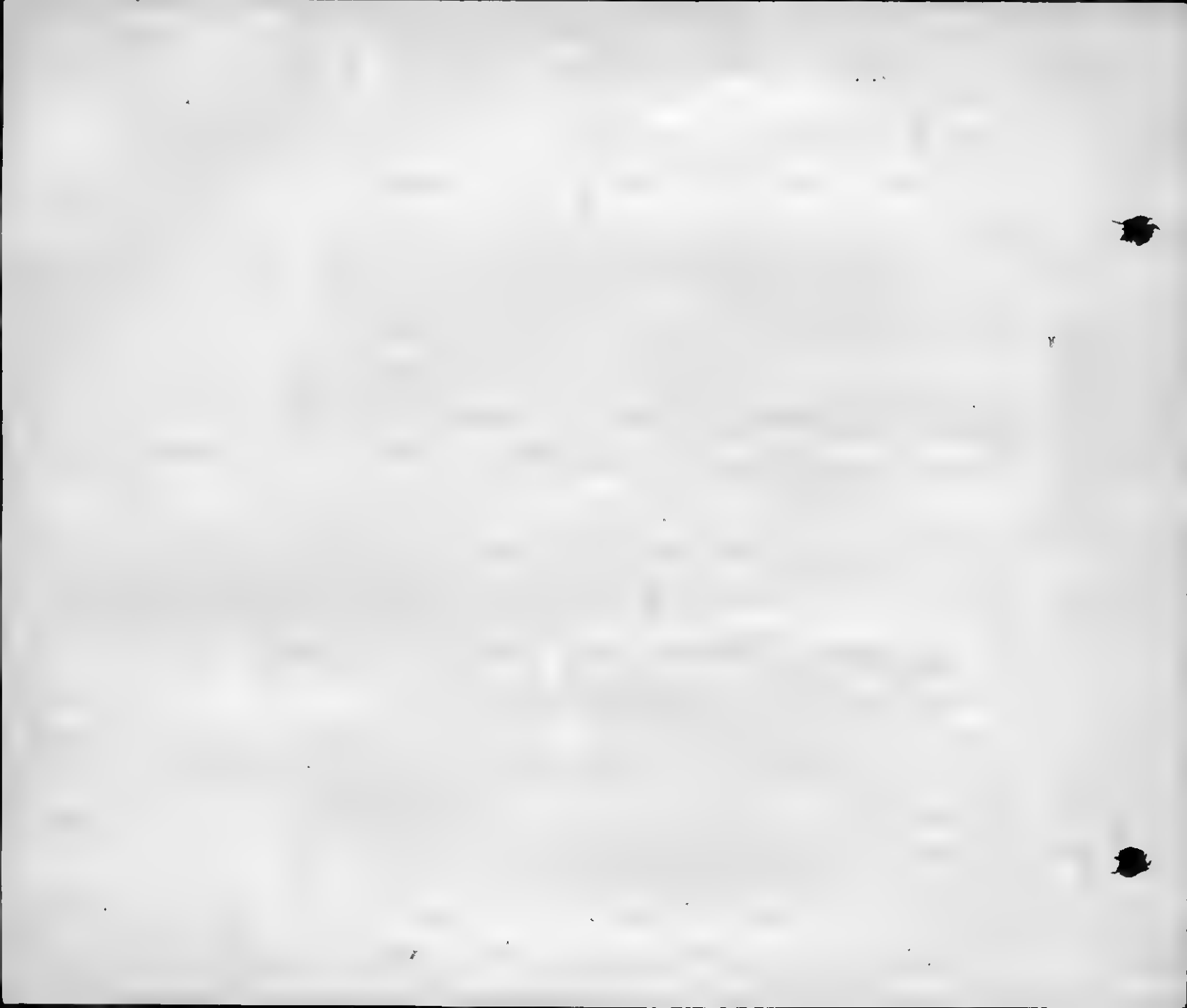
8276

08241

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b 3 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERTHA Middle -- Last SELBY				4. DATE OF DEATH Month JULY Day 10 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/7/84	
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME WILLIAM CLAUSSEN				14. MOTHER'S MAIDEN NAME AGNES BECK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT HOSPITAL RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Emboli Pulmonary DUE TO Thrombosis Femoral Veins Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) Not Known.							INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)			(County)			(State)	
21. I certify that (I) (this hospital) attended the deceased from July 8 19 60 to July 10 19 60 that (I) (we) last saw the deceased alive on July 10 1960 and that death occurred at 10 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Jack Schumacher M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7/11/60	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.				22d. ADDRESS GAITHERSBURG, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF July 13-60		23c. NAME OF CEMETERY OR CREMATORY St. Mary's		23d. LOCATION (City, town, or county) (State) Rockville Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Shirley E. Smith				ADDRESS Gaithersburg, Md.		25a. REC'D BY REGISTRAR DATE JUL 13 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			



1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyer</u>		c. LENGTH OF STAY IN IB <u>1/2 day</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Go Chadwick Farm - Boyer md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Garland Richard Sexton</u>		4. DATE OF DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-43</u>	
9. AGE (in years last birthday) <u>17</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>7</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Geo R. Sexton</u>		14. MOTHER'S MAIDEN NAME <u>Leonia F. McAlexander</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Geo R. Sexton - Item 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>drowning</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Asphyxia</u> DUE TO (c) <u>drowning</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I:		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>drowned in pond while swimming</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-15</u> Hour <u>6:00</u> P.m. <u>7-3</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Farm</u>		20f. (City or town) <u>Boyer</u> (County) <u>Montgomery</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschew</u> M.D.		DATE SIGNED <u>7-3-60</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschew</u>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 5, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Church Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Germanstown Md.</u>	
23. FUNERAL DIRECTOR <u>E.C. Gartner - Gaithersburg, Md.</u>		24a. REC'D BY REG STRAR DATE <u>JUL 6 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles L. Hous</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

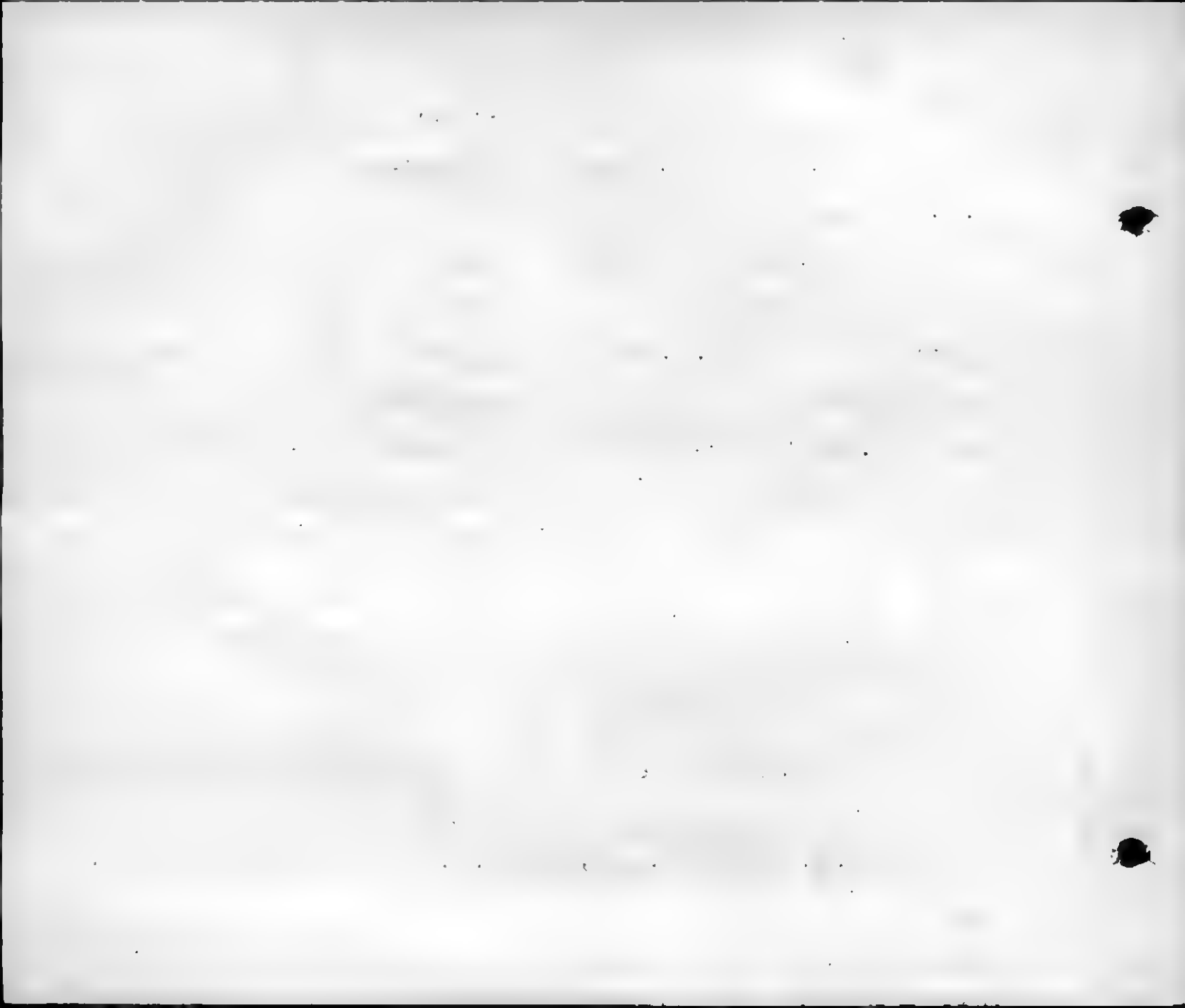
CERTIFICATE OF DEATH

8278

18243

Item 2 Baltimore 8-5-60 et

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 15 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Marlboro d. STREET ADDRESS RFD Box 3350 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Carl Rudolph SMITH			4. DATE OF DEATH Month Day Year July 29 1960				
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-15-12	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) Alabama			
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Walter R. SMITH				
14. MOTHER'S MAIDEN NAME Nena EDWARDS			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII-Korean				
16. SOCIAL SECURITY NO. 418-14-7350			17. INFORMANT (W) Mrs. Ellen D. Smith, same as #2 above				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure 434.4 DUE TO Primary Pulmonary Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Thoracotomy 2 days ante mortem (c) 1 day INTERVAL BETWEEN ONSET AND DEATH 2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Thoracotomy 2 days ante mortem							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thoracotomy 2 days ante mortem					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from July 14 1960 to July 29 1960 , that (I) (we) last saw the deceased alive on July 29 1960 , and that death occurred at 0920AM from the causes and on the date stated above.							
22a. SIGNATURE C. A. Broadbudd, Jr.		22b. DATE SIGNED 7-29-60		22c. PHYSICIAN'S NAME (Type) C. A. BROADBUD, JR., CDR MC, USN U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-2-60		23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.			
23d. LOCATION (City, town, or county) Croom, Maryland		23e. (State) Md.		23f. (Country) USA			
24. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Funeral Home, Upper Marlboro, Md.		25a. REC'D BY REGISTRAR DATE AUG 2 '60		25b. REGISTRAR'S SIGNATURE Arthur L. House			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

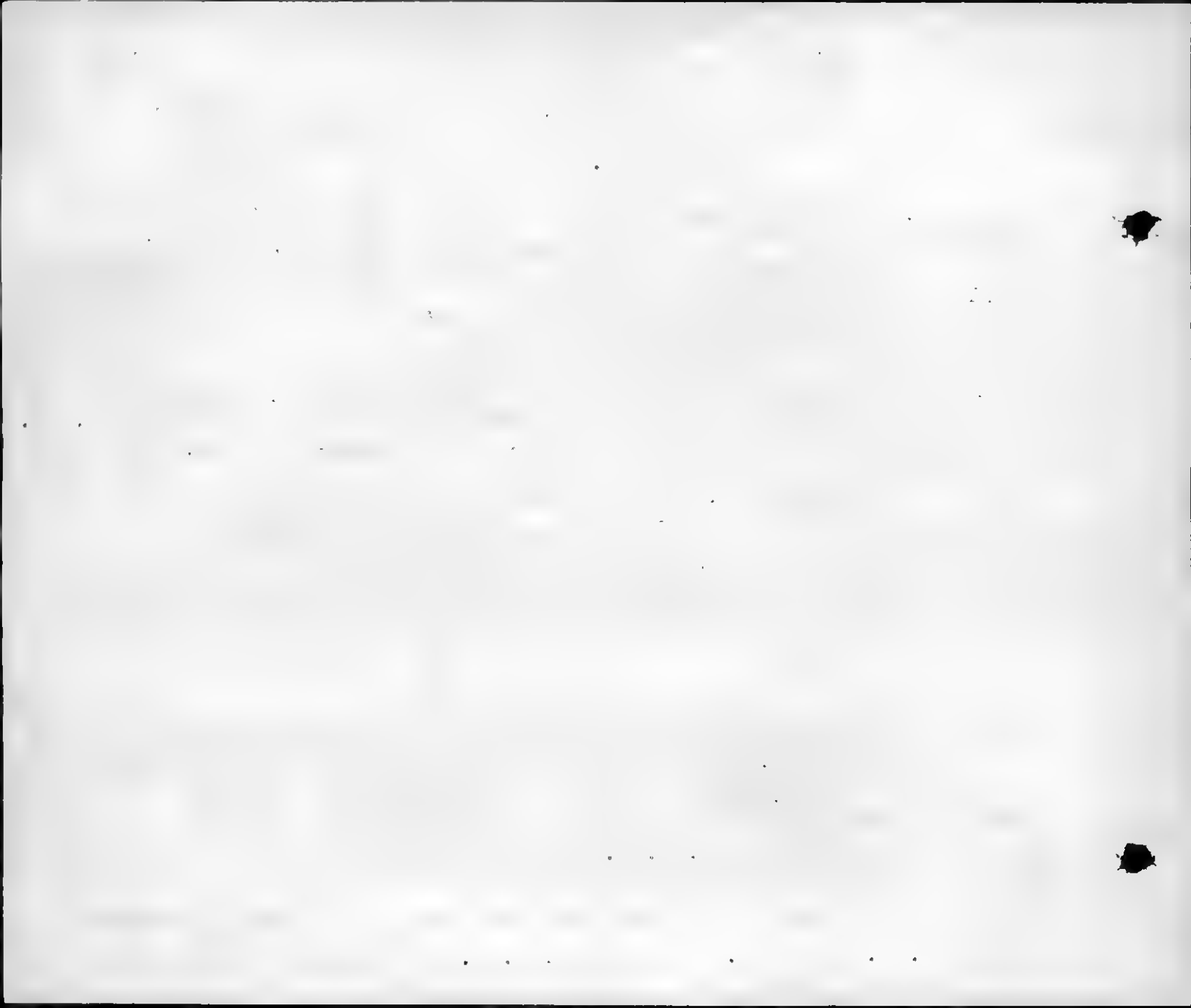
CERTIFICATE OF DEATH

8175

Item 12 filed 8-4-60 et

0824

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
c. LENGTH OF STAY IN TB 9 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Hall Sanitarium 10231 Carroll Place		e. STREET ADDRESS 7205 Honeywell Lane	
3. NAME OF DECEASED (Type or print) Thomas First Middle Last Stevenson		4. DATE OF DEATH Month July Day 31 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1876
9. AGE (In years last birthday) 84 yrs		10. UNDER 1 YEAR: Months 8 Days 4 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive - Textile Industry		10b. KIND OF BUSINESS OR INDUSTRY Industry	
11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Stevenson		14. MOTHER'S MAIDEN NAME Unobtainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 061-07-4718	
17. INFORMANT Mrs. James Heaton-7205 Honeywell Lane		Address Bethesda, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory Failure DUE TO 422-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic cardiovascular disease DUE TO 10 years (c) Atherosclerosis of old age DUE TO 10 years		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/4/60 to 7/31 , 19 60 , that (I) (we) last saw the deceased alive on 7/31/60 , 19 60 , and that death occurred at 7:25 P.M. , from the causes and on the date stated above			
22a. SIGNATURE Samuel Diener		22b. DATE SIGNED 7/31/60	
22c. PHYSICIAN'S NAME (Type) Samuel Diener, M. D.		22d. ADDRESS 4201 MASS. AVE. N.W. WASH, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 8/2/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Cemetery		23d. LOCATION (City, town, or county) (State) Patterson, New Jersey	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.		25a. REC'D BY REGISTRAR Washington, D. C.	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines		DATE AUG 2 '60	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8176

CERTIFICATE OF DEATH

18245

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens SAN.</u>		d. STREET ADDRESS <u>3015 13th ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Edith Scheinerman Sugar</u>		4. DATE OF DEATH Month <u>7</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housew. Fe.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Issac Scheinerman</u>		14. MOTHER'S MAIDEN NAME <u>ANNA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>MAX MEYERS</u>		Address <u>507-DECATUR NW. DC</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artero-sclerosis</u> DUE TO (c) <u>Cerebro-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Thrombosis (old) May 23, 1960</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 3, 1952</u> to <u>July 20, 1960</u> , that I last saw the deceased alive on <u>July 19, 1960</u> , and that death occurred at <u>8:10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.		ADDRESS (Street, city or town, state) <u>1216 20th St. N.W. Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		DATE SIGNED <u>July 20, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>7/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>S.E. HELEW CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>DC.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Willie Ferguson</u>		24a. REC'D BY REGISTRAR <u>Jul 22 '60</u>	
ADDRESS <u>4717 9th St. N.W. Wash., D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

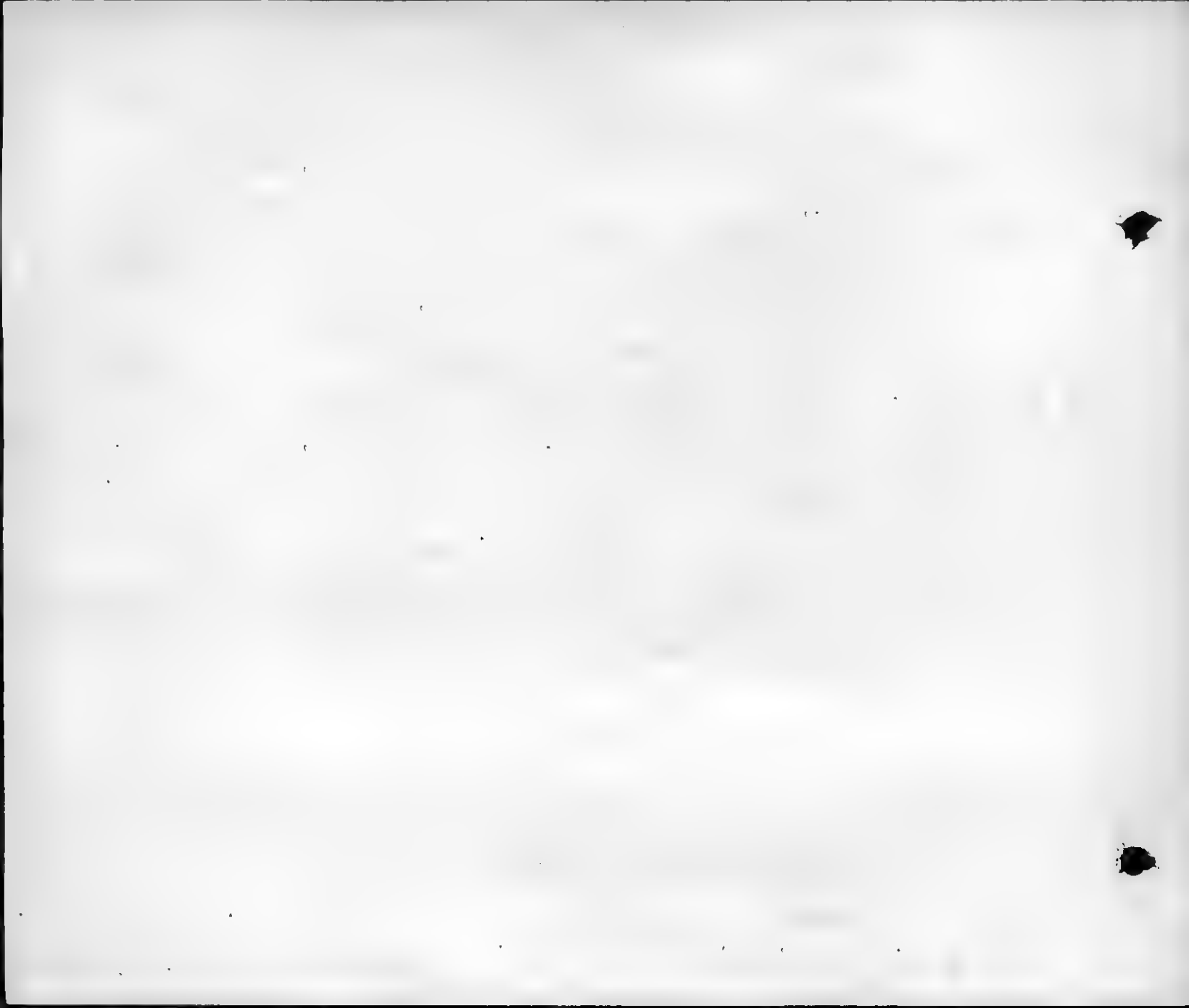


may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
81777 CERTIFICATE OF DEATH 08246

1 PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE MARYLAND b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3513 NIMITZ RD..				e. STREET ADDRESS 9307 SAYBROOK AVENUE			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle ANN Last SYLVESTER				4. DATE OF DEATH Month JULY Day 15 Year 19 60			
5 SEX FEMALE		6 COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 13, 1873	
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ennis B. Lyle				14. MOTHER'S MAIDEN NAME Martha (unknown)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Granville Sylvester, 3513 Nimitz Rd., Kensington, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sinus Venosus & Cerebral Arteriosclerosis</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/30/1960</u> to <u>7/15/1960</u> that (I) (we) last saw the deceased alive on <u>7/14/1960</u> and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Russell B. Arnold</u> M.D.				22b. ADDRESS <u>8301 Col. ...</u>			
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>				22d. ADDRESS <u>Silver Spring, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF unknown		23c. NAME OF CEMETERY OR CREMATORY unknown		23d. LOCATION (City, town, or county) (State) CHRISTIAN CTY., HOPKINSVILLE, KY.	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD.</u> <u>Raymond A. Ziske</u>				25a. REC'D BY REGISTRAR DATE JUL 19 '60		25b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>	



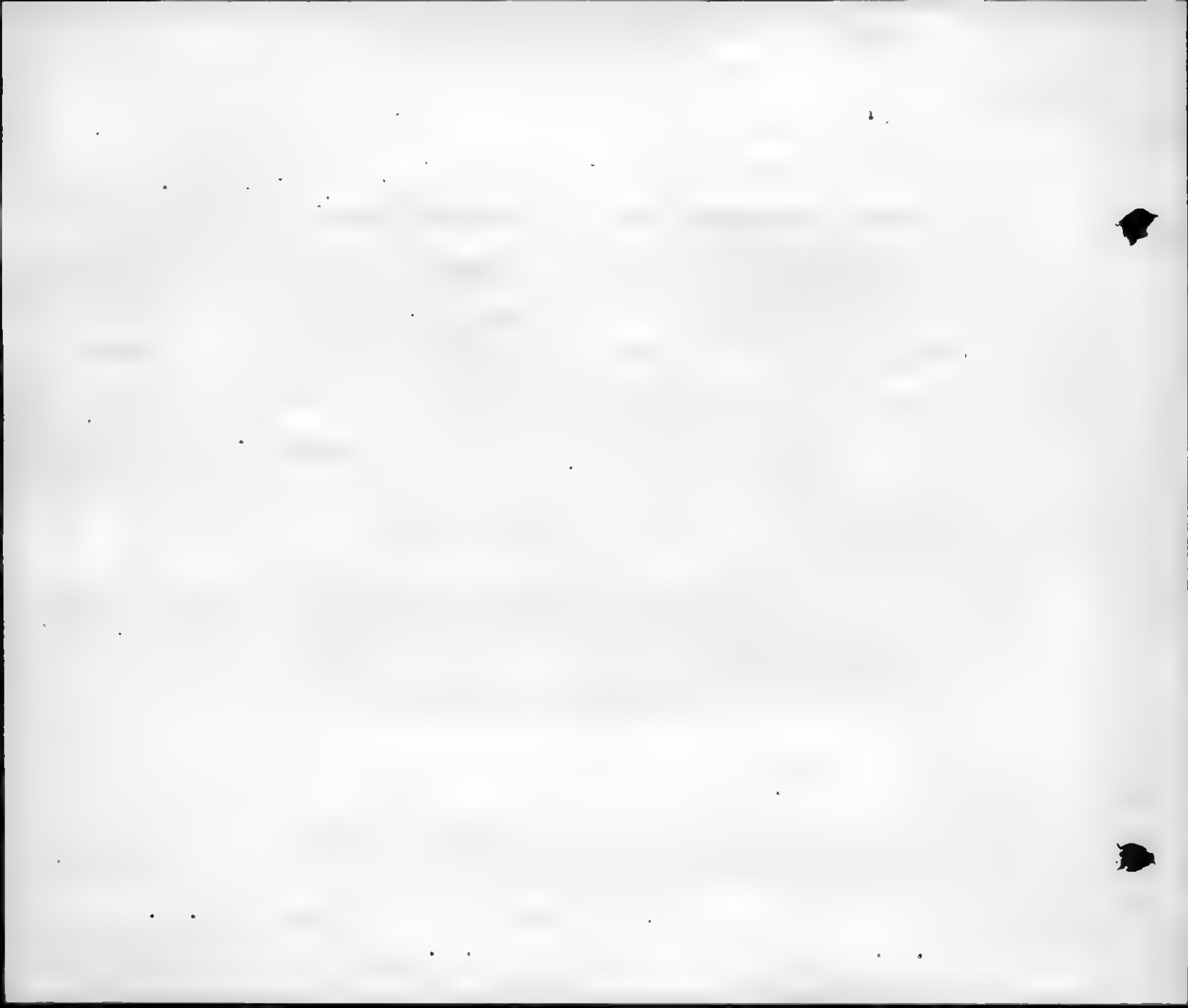
8154

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

08247

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
c. LENGTH OF STAY IN 1b <u>2 1/2 mo.</u>		d. STREET ADDRESS <u>1236 Underwood St. NW</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oakhaven, 517 Albany Ave</u>		IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stamata</u> Middle <u>Tagalos</u> Last <u>Tagalos</u>		4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>1960</u>	
5 SEX <u>F.</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>May 21, 1875</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11 BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u> ✓	
13. FATHER'S NAME <u>Argeres Nicolopoulos</u>		14. MOTHER'S MAIDEN NAME <u>Alice Theoropoulos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Frank (daughter)</u>		Address <u>Wash. D.C. 1745 Irving St. NW</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> 332 x. DUE TO <u>Cerebral Arteriosclerosis & Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Old age, free hyp. & atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 20, 1960</u> to <u>July 30, 1960</u> that (I) (we) last saw the deceased alive on <u>July 23, 1960</u> and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas. H. Violot Hon</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas. H. Violot Hon</u>		22d. ADDRESS <u>600 Underwood St NW</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/2/60</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Company</u>		25a. REC'D BY REGISTRAR <u>Aug 2 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

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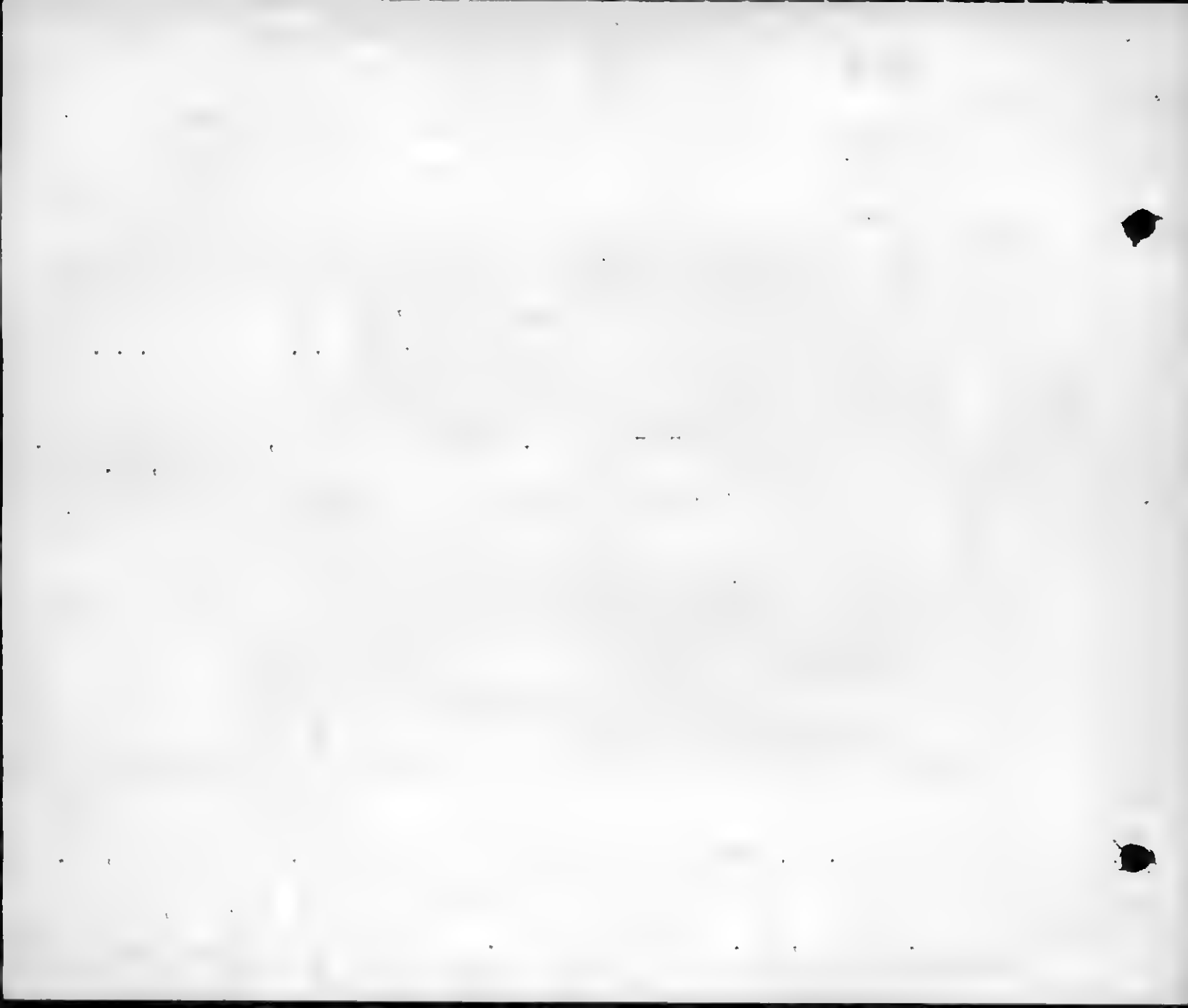
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

118248

8155

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MONTGOMERY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md</u>				c. LENGTH OF STAY IN 1b <u>233 Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. San. Hosp.</u>				d. STREET ADDRESS <u>19313 Colesville Rd</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Donaldson</u> Last <u>Taggart</u>				4. DATE OF DEATH Month <u>7</u> Day <u>25</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 13, 1894</u>		9. AGE (In years last birthday) <u>66</u> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Taggart</u>				14. MOTHER'S MAIDEN NAME <u>Ann Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>WW #1 213-38-1924</u>		17. INFORMANT Address <u>Mrs. Clare Regina Taggart, 9313 Colesville Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>following coronary artery thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>Diabetes mellitus</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u>Diabetes mellitus</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1956</u> to <u>July 25, 1960</u> that (I) (we) last saw the deceased alive on <u>July 25, 1960</u> and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D.				22b. DATE <u>7/25/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>ERNEST E. HARMON</u>				22d. ADDRESS <u>9301 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/28/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR <u>JUL 29 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

8156

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

18249

Reg. Dist. No.

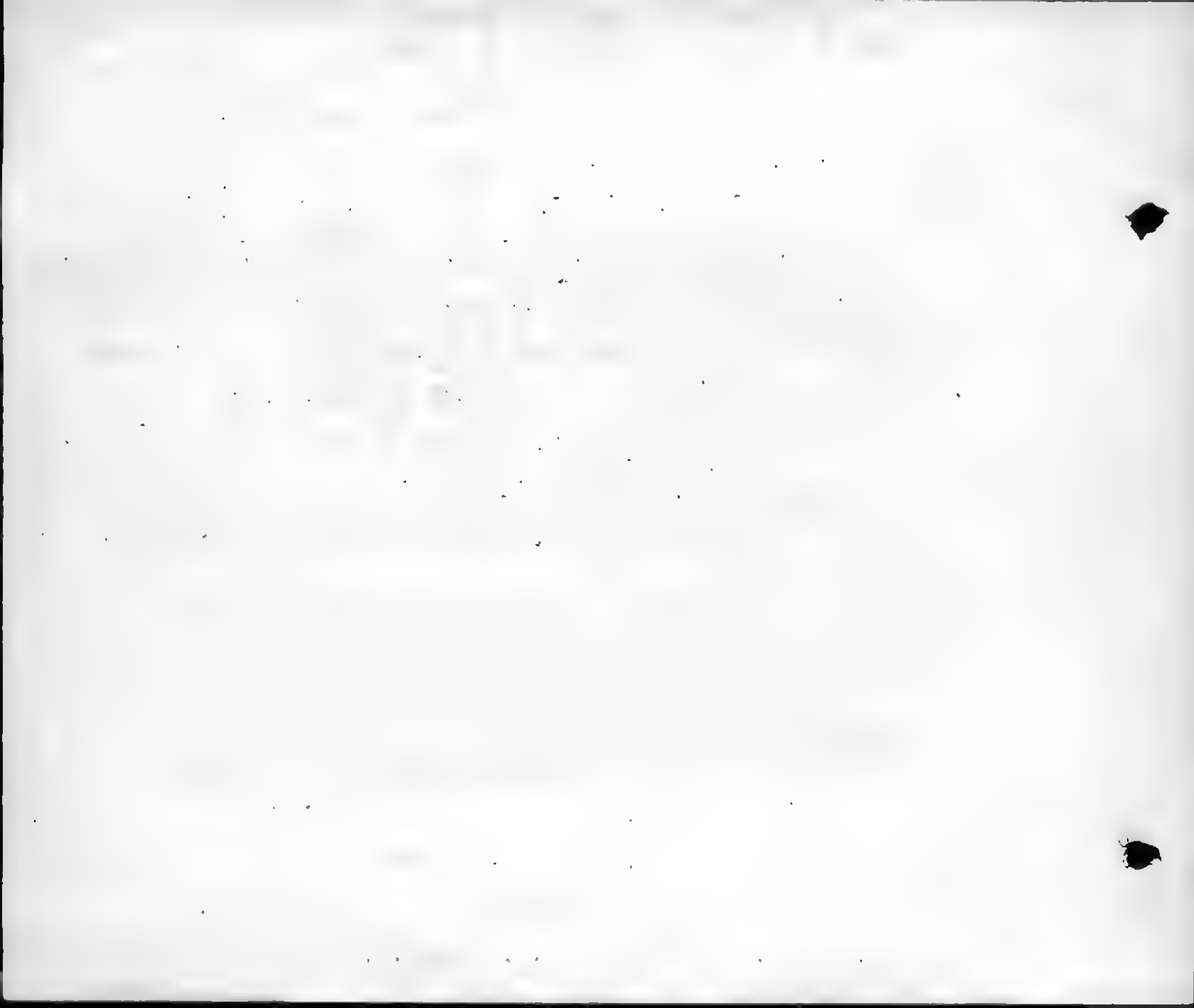
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>2 months</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>1222 Falls Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Romaine</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-27-'15</u>
9. AGE (In years last birthday) <u>45</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assemblee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elect. Teaching Lab.</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>HARRY C. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Sue Waughtel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Wash. San Hospital Records Takoma Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X Generalized Metastatic Carcinoma</u> DUE TO (b) <u>Duct Carcinoma (rt. breast)</u> DUE TO (c) <u>18 mos</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-29, 1960</u> to <u>7-30, 1960</u> that I last saw the deceased alive on <u>7-30, 1960</u> , and that death occurred at <u>12:12 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul V. Starr</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave.</u> DATE SIGNED <u>7-30-60</u>	
PHYSICIAN'S NAME (Type) <u>PAUL V. STARR</u>		<u>Takoma Park, Md.</u>	
22a. BURIAL, CREMATION OR DISPOSAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-1-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Red Lion Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Red Lion, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home. - 300-4th St N.E. Wash D.C.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>Aug 2 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

(M)

(I)

(D)

MEDICAL CERTIFICATION



8279

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Virginia		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 9 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dahlgren		827-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS Qtrs. 907, Naval Weapons Lab.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Benjamin		Middle TEATS, JR.		Last July 13 1960	
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH July 13 1960	
9. AGE (In years last birthday) 62 yrs.		10. BIRTHPLACE (State or foreign country) New York		11. DATE OF BIRTH 5-11-98		12. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mariner		10b. KIND OF BUSINESS OR INDUSTRY U. S. Navy		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin TEATS				14. MOTHER'S MAIDEN NAME Ella WOODS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI & WWII		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease DUE TO And Coronary Artery Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: And Coronary Artery Occlusion (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Auto Chronic Cholelithiasis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from July 4 1960 to July 13 1960 , that (I) (we) last saw the deceased alive on July 12 1960 , and that death occurred at 3A M, from the causes and on the date stated above							
22a. SIGNATURE W. D. HOOVER		M. D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 7-13-60	
22c. PHYSICIAN'S NAME (Type) W. D. HOOVER, LT, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-18-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Everly Wheatley		ADDRESS Elkins Funeral Home, 613 Caroline St., Fredericksburg, Va.		25a. REC'D BY REGISTRAR JUL 15 '60		25b. REGISTRAR'S SIGNATURE Colleen S. Kneib	



8129

CERTIFICATE OF DEATH

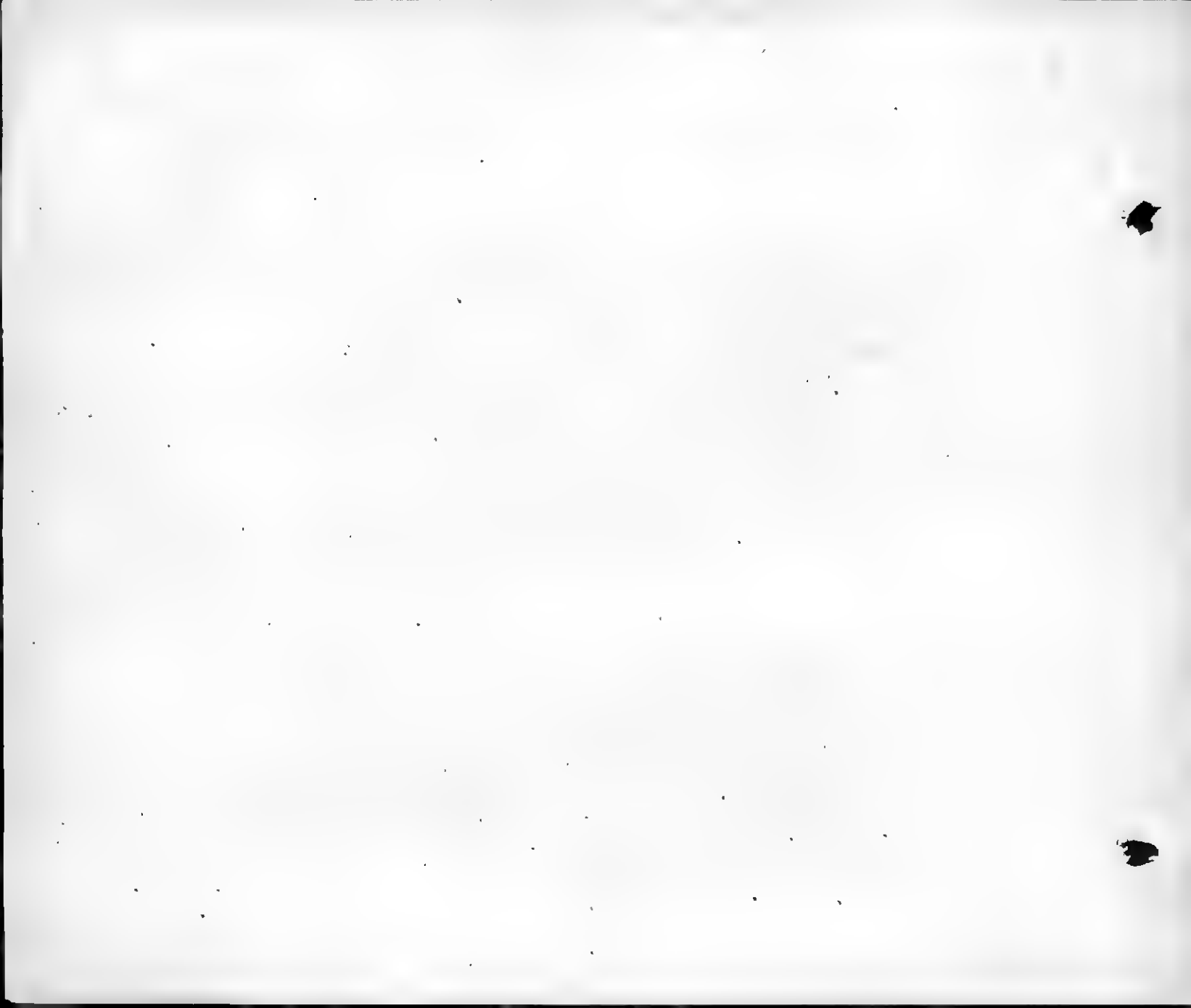
Reg. Dist. No.

08251

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS 2904 FENIMORE RD.	
3. NAME OF DECEASED (Type or print) SAMUEL - Terman		4. DATE OF DEATH Month JULY Day 25 Year 1960	
5. SEX MALE	6. COLOR OR RACE WH.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29-'88
9. AGE (in years last birthday) 71 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INS. AGENT (RET.)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME DAVID Terman		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 222-09-6569	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 420 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVA. BETWEEN ONSET AND DEATH. APPROX 10 MIN. 13 YRS.		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) DUODENAL ULCER WITH GASTROJEJUNOSTOMY			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/11 , 19 60 , to 7/25 , 19 60 , that I last saw the deceased alive on 7/23 , 19 60 , and that death occurred at 10:30 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE David Goldenberg M.D.		ADDRESS (Street, city or town, state) 10620 GEORGIA DATE SIGNED 7/25/60	
PHYSICIAN'S NAME (Type) DAVID GOLDENBERG		SILVER SPRING, MARYLAND	
22a. BURIAL, CREMATON, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	7-26-60	NAT'L MEM. PARK	FALLS CH. VA.
23. FUNERAL DIRECTOR'S SIGNATURE Goldberg Funeral Home ADDRESS 4217-9th Ave		24a. REC'D BY REGISTRAR DATE JUL 26 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO HOSPITAL: THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

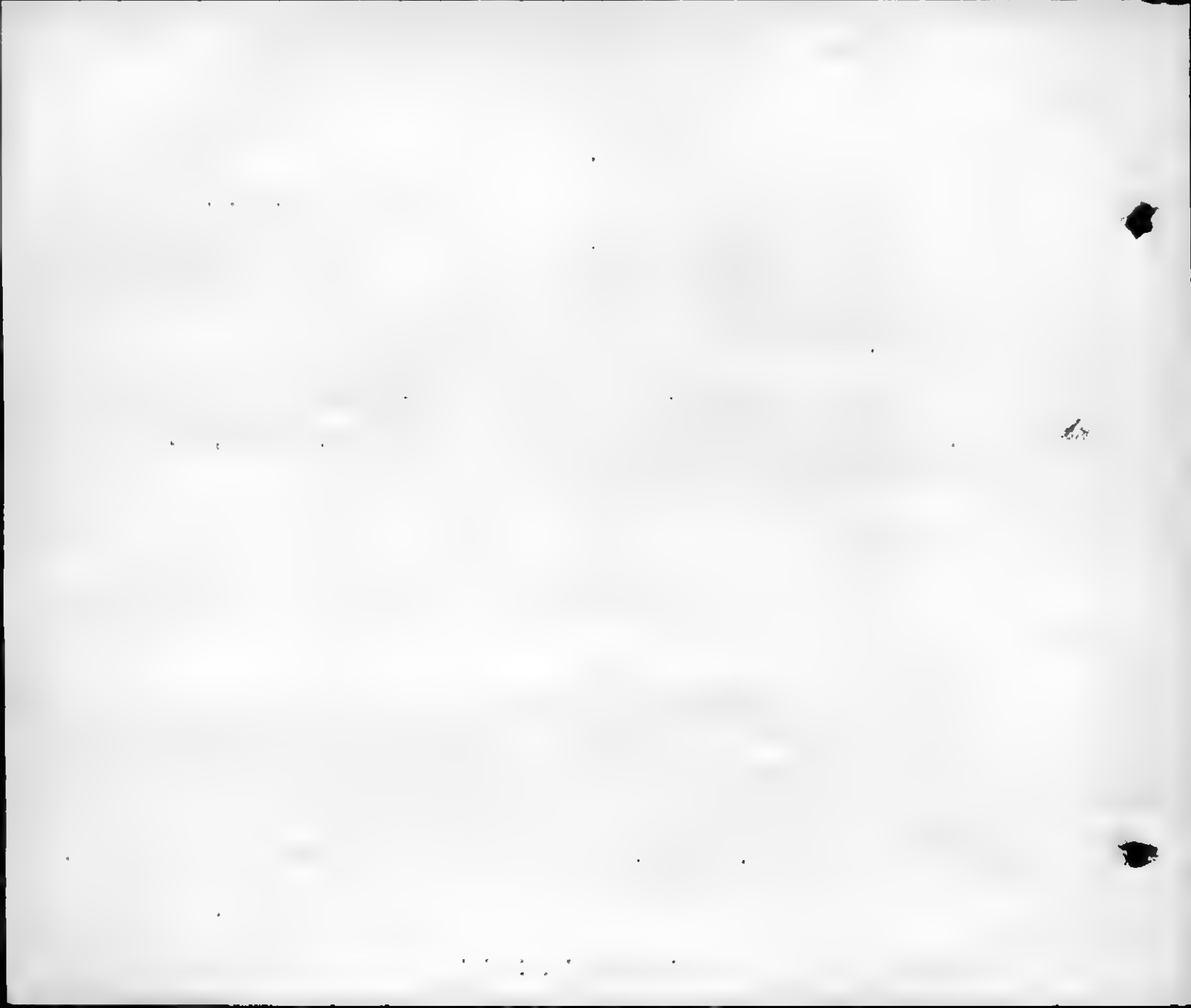
8/29/60
mnB

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8280

09381

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE DC b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wheaton Nursing Home		d. STREET ADDRESS 4049 First St., S.W.	
3. NAME OF DECEASED (Type or print) First Benjamin Middle Earl Last Thompson		4. DATE OF DEATH Month July Day 24 Year 60	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/10/88
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 10 Days 4 Hours 10 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov't. Clerk		10b. KIND OF BUSINESS OR INDUSTRY Gov't	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Paxton Greyer Thompson		14. MOTHER'S MAIDEN NAME Frances Border	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Wheaton Nursing Home, Wheaton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 527.1 DUE TO Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 10 19 60 to July 24 19 60, that (I) (we) last saw the deceased alive on July 24 19 60, and that death occurred at 4:45 PM from the causes and on the date stated above.			
22a. SIGNATURE Dr. James M. Whitlock		22b. DATE SIGNED 7 24 60	
22c. PHYSICIAN'S NAME (Type) Dr. James M. Whitlock		22d. ADDRESS 7701 Carroll Avenue, Takoma Park, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/60	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Gawler's Cons, Inc.		25a. REC'D BY REGISTRAR SEP 6 '60	
ADDRESS 1756 Pa. Ave., N.W. Washington, D.C.		25b. REGISTRAR'S SIGNATURE Arthur S. Hayes	



8281

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08252

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY c. LENGTH OF STAY IN 1b 13 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLARKSBURG d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LULA Middle MIRANDA Last THOMPSON				4. DATE OF DEATH Month JULY Day 7 Year 19 60			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 7, 1895	
9. AGE (in years last birthday) 65 64 yrs.		10. IF UNDER 1 YEAR: Months 64 Days 64 Hours 64 Min.		11. IF UNDER 24 HRS.			
10a. US J.A. OCCUPATION (Give kind of work done during most of working life, even if retired) House-work				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME TITIS BENNETT				14. MOTHER'S MAIDEN NAME ANNIE MURRAY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO None		17. INFORMANT Address HOSPITAL RECORDS, OLNEY, MD.	
18. CAUSE OF DEATH (Enter only one cause part (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Pyelonephritis, bilateral DUE TO Chronic Pyelonephritis, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 5 yrs (c) 2 wks.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/27/60 to 7/7/60 , that () (we) last saw the deceased alive on 7/7/60 , and that death occurred on 7/7/60 , from the causes and on the date stated above.							
22a. SIGNATURE [Signature] M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. DATE SIGNED 7/8/60							
22c. PHYSICIAN'S NAME (Type) C. H. LIGON, M. D.				22d. ADDRESS SANDY SPRING, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-10-60		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Hyattstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. L. Burdette, Hyattstown, Maryland				25a. REC'D BY REGISTRAR DATE JUL 11 '60		25b. REGISTRAR'S SIGNATURE [Signature]	



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 4 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

M

8157
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08253

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. Genl Hosp</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>3009 Jefferson St</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Maria Wilhelmina</u> 4. SEX <u>Female</u> 5. COLOR OR RACE <u>White</u> 6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. DATE OF BIRTH <u>1-20-73</u> 8. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>19</u> Hours <u>00</u> Min.		9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (State or foreign country) <u>Germany</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Johann Wilbrecht</u> 14. MOTHER'S MAIDEN NAME <u>Wilhelmina</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>PH. Hospital record</u> 17. INFORMANT <u>H. Hospital record</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of the cervical spine</u> DUE TO (b) <u>Trauma resulting from a fall down the stairs</u> DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u> 20c. TIME OF INJURY Month, Day, Year <u>7-15-60</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Wheaton</u> (County) <u>Montgomery</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Frank J. Broschant</u> M.D. EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>7-20-60</u>		DATE SIGNED <u>7-20-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>7/23/60</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u> 22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>		23. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 E. Montgomery Ave. Rockville, Maryland</u> 24a. REC'D BY REGISTRAR <u>JUL 25 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



8178

CERTIFICATE OF DEATH

08254

Reg. Dist. No.

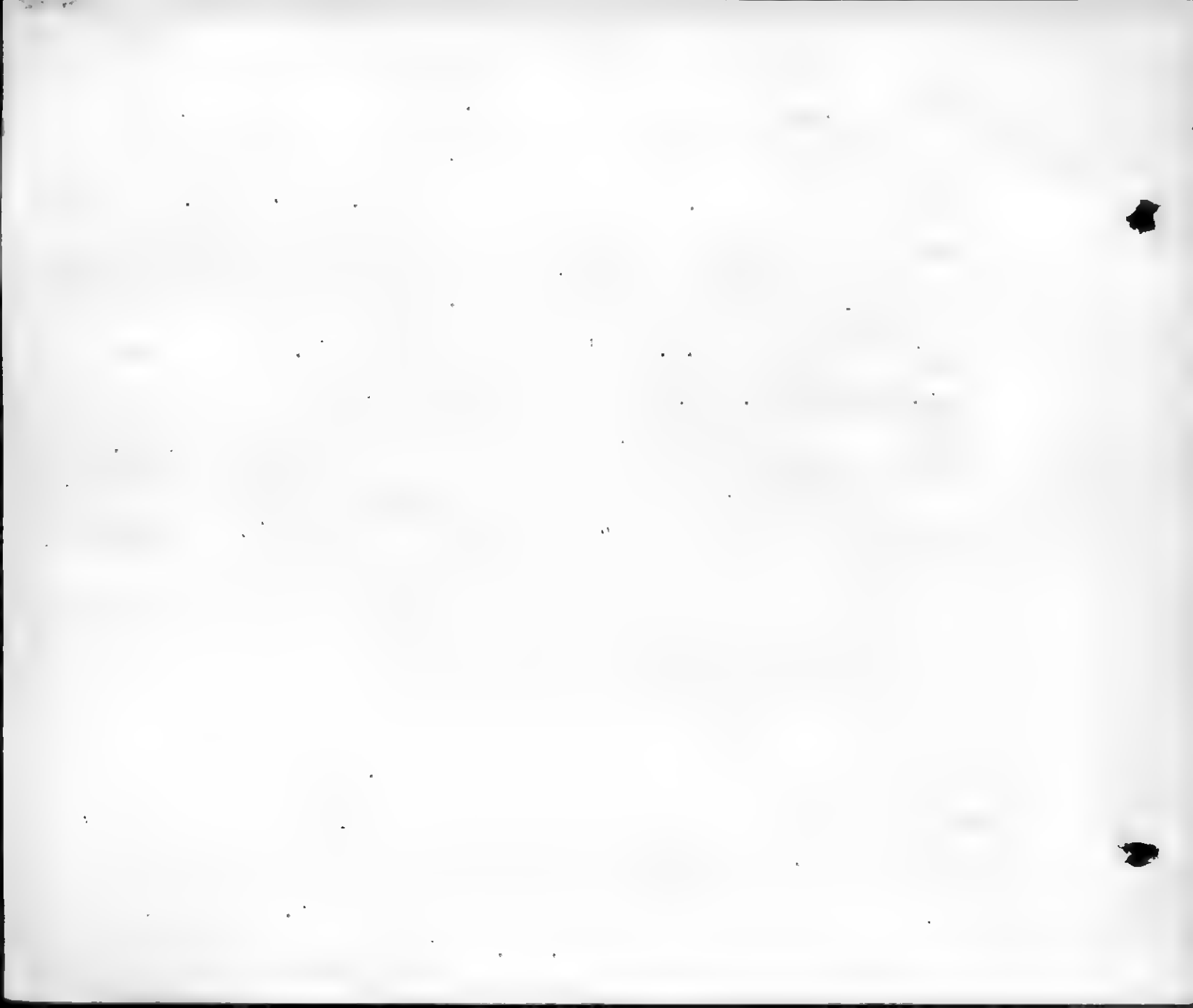
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Hall San.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Damascus</u>	
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Hilton</u> Last <u>Todd</u>		4. DATE OF DEATH Month <u>July</u> Day <u>9</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk-Typist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>	
11. BIRTHPLACE (State or foreign country) <u>Clarksburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Dr. Benjamin H. Todd</u>		14. MOTHER'S MAIDEN NAME <u>Laura F. Hilton</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-2998</u>	
17. INFORMANT <u>Mrs Paul Watkins, Damascus, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 years</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 10, 1960</u> to <u>July 9, 1960</u> that I last saw the deceased alive on <u>July 5, 1960</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James P. Kerr</u>		ADDRESS (Street, city or town, state) <u>Damascus, Md.</u>	
PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		DATE SIGNED <u>7/10/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 11, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>		22d. LOCATION (City, town, or county) (State) <u>Mt. Airy, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Olin L. Moleworth</u>		ADDRESS <u>Damascus, Md.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>Jul 12 '60</u>			

1 after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 days after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please replace carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

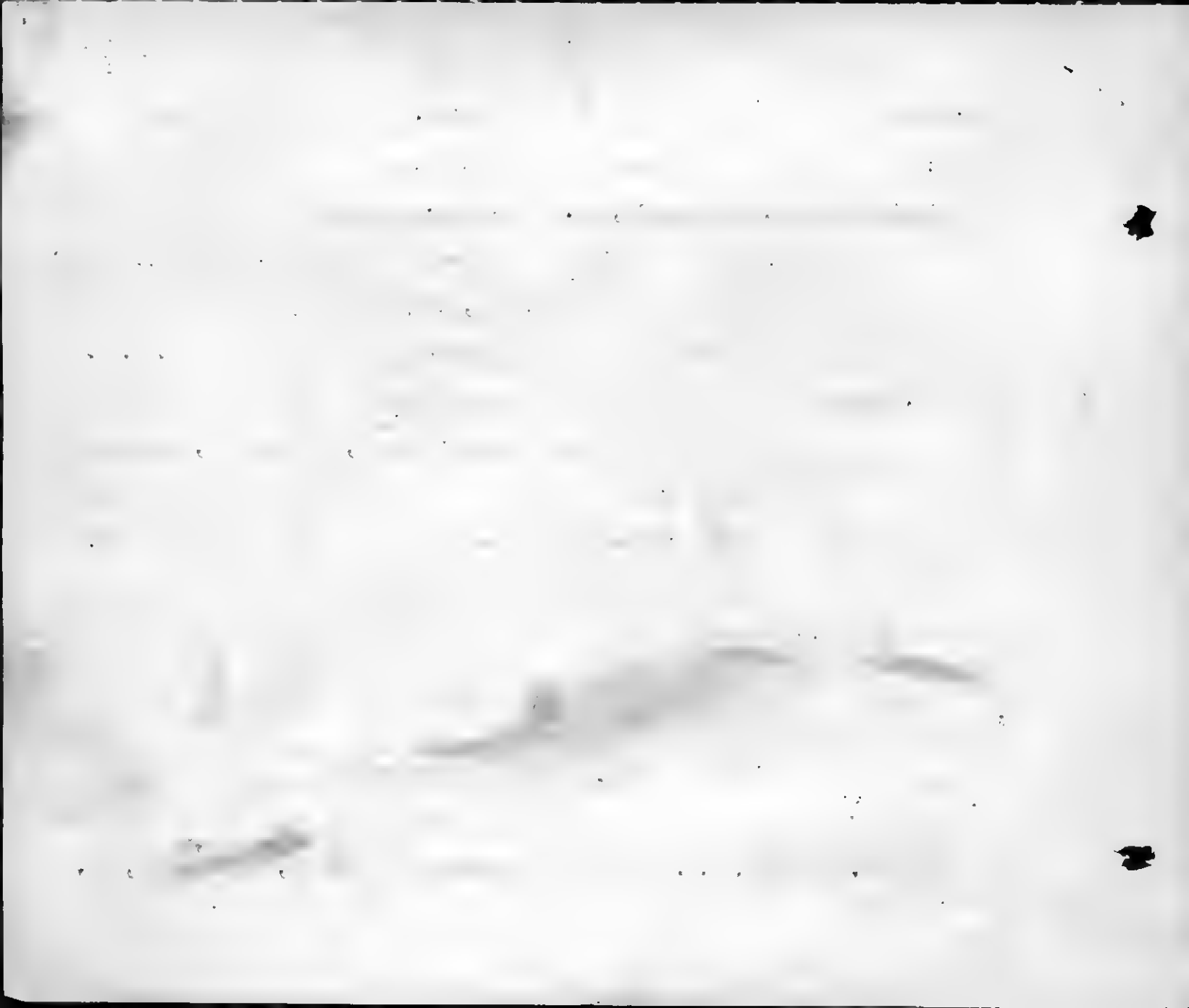
VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

8282

08255

1 PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 46 days		2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Virginia b. COUNTY Augusta c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Solon d. STREET ADDRESS No street address	
3 NAME OF DECEASED (Type or print) First Sue Middle Gail Last Toombs		4 DATE OF DEATH Month July Day 16 Year 1960	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 4, 1957
9 AGE (In years lost birthday) 3 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min 3	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY None	
11 BIRTHPLACE (State or foreign country) Virginia		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13 FATHER'S NAME Alvin L. Toombs		14 MOTHER'S MAIDEN NAME Lucy Redifer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda 14, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Septicemia 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute lymphatic leukemia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Vulval tumor and hematoma			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 31 19 60 , to July 16 19 60 , that (I) (we) last saw the deceased alive on July 16 19 60 and that death occurred at 11:34 PM on the causes and on the date stated above.			
22a SIGNATURE Robert B. Scoggins		22b DATE SIGNED 7/17/60	
22c PHYSICIAN'S NAME (Type) Robert B. Scoggins, M.D.		22d ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.	
23a BURIAL, CREMATION, or other disposition Burial - Transit		23b DATE THEREOF 7/17/60	
23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		23d LOCATION (City, town, or county) (State) Mt. Solon, Va.	
24 FUNERAL DIRECTOR'S SIGNATURE Robert A. Humphrey		25a REC'D BY REGISTRAR Bethesda, Maryland	
25b REGISTRAR'S SIGNATURE Arthur S. Kline		DATE JUL 19 '60	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 08256										
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7008 Hillcrest Place					d. STREET ADDRESS 7008 Hillcrest Place					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle ANNE Last TUCKER					4. DATE OF DEATH Month July Day 16 , Year 1960					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 17, 1895		9. AGE (In years last birthday) 64 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hartford, Conn.		12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME John Flanagan					14. MOTHER'S MAIDEN NAME Elizabeth McBride					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Husband Ray Tucker		Address Same as Item #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO Conditions, if any, which gave rise to immediate cause (b) Massive gastro-intestinal hemorrhage (c) Carcinoma of the Neck with Metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate ' Years										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE Frank J. Broschart M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Frank J. Broschart					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 7/19/60		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey					ADDRESS Bethesda, Maryland		24a. REC'D BY REGISTRAR DATE JUL 19 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

DATE SIGNED
July 16, 1960

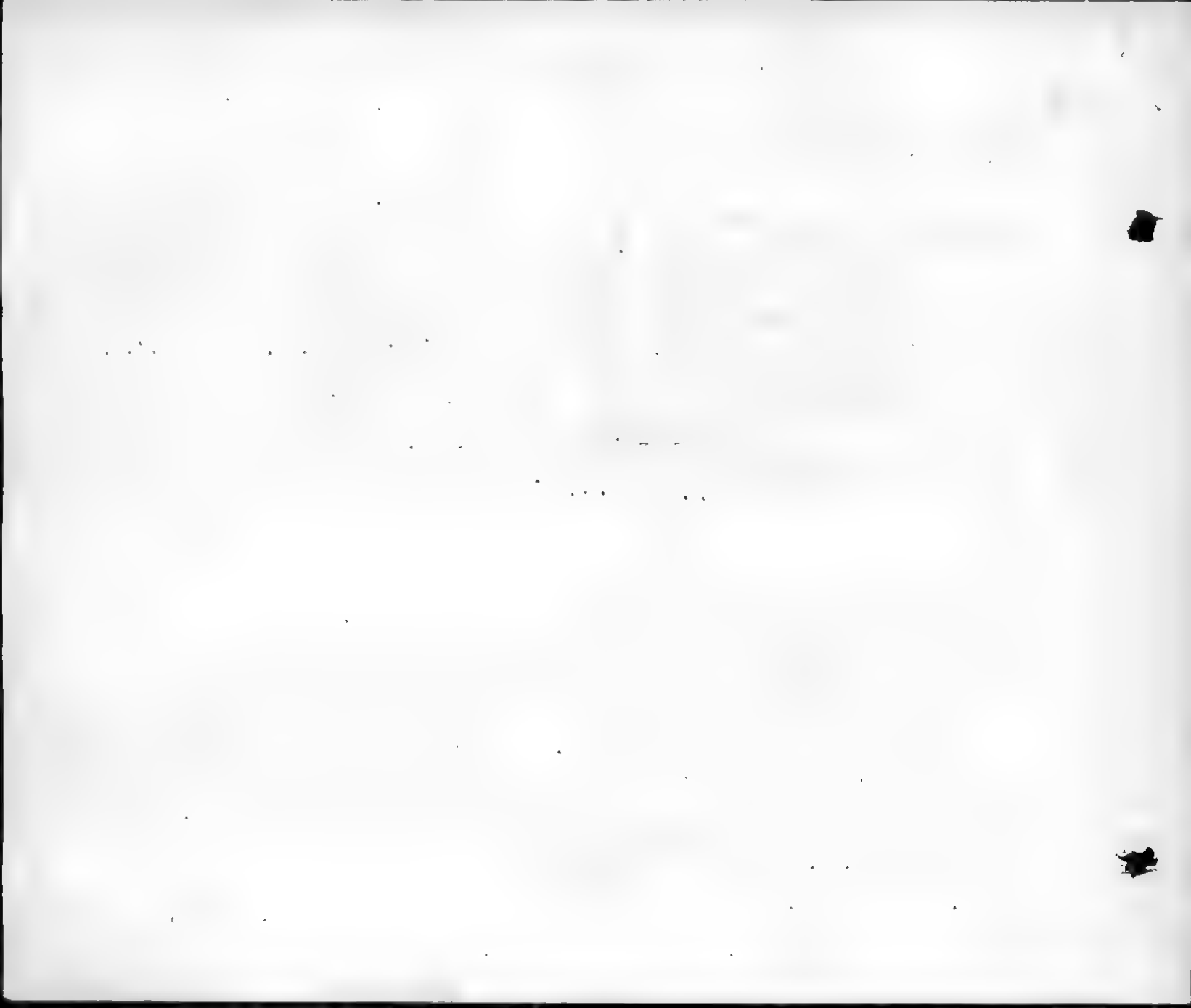


Reg. Dist. No.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

18258

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY COUNTY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA, MD.</u>		c. LENGTH OF STAY IN 15 <u>12 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		d. STREET ADDRESS <u>17 ALBERMYRTLE</u>	
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>BUSTER</u> Last <u>VAUGHAN</u>		4. DATE OF DEATH Month <u>JULY</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 14 1905</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>37</u> Min <u>57</u>	IF UNDER 24 HRS Months <u>5</u> Days <u>17</u> Hours <u>37</u> Min <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FURNITURE</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JAMES THOMAS VAUGHAN</u>		14. MOTHER'S MAIDEN NAME <u>LENA THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO (If yes, give war or dates of service) <u>EDWARD H. VAUGHAN</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Edeema</u> 162.1 DUE TO <u>Melastatic Tumor</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last DUE TO <u>Bronchial Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>7-14</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-14</u> , 19 <u>60</u> , to <u>7-23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>7-23</u> , 19 <u>60</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8218 WISCONSIN AVE</u> DATE SIGNED <u>Francis C. Mayle Jr.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Francis C. Mayle Jr.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. K...</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

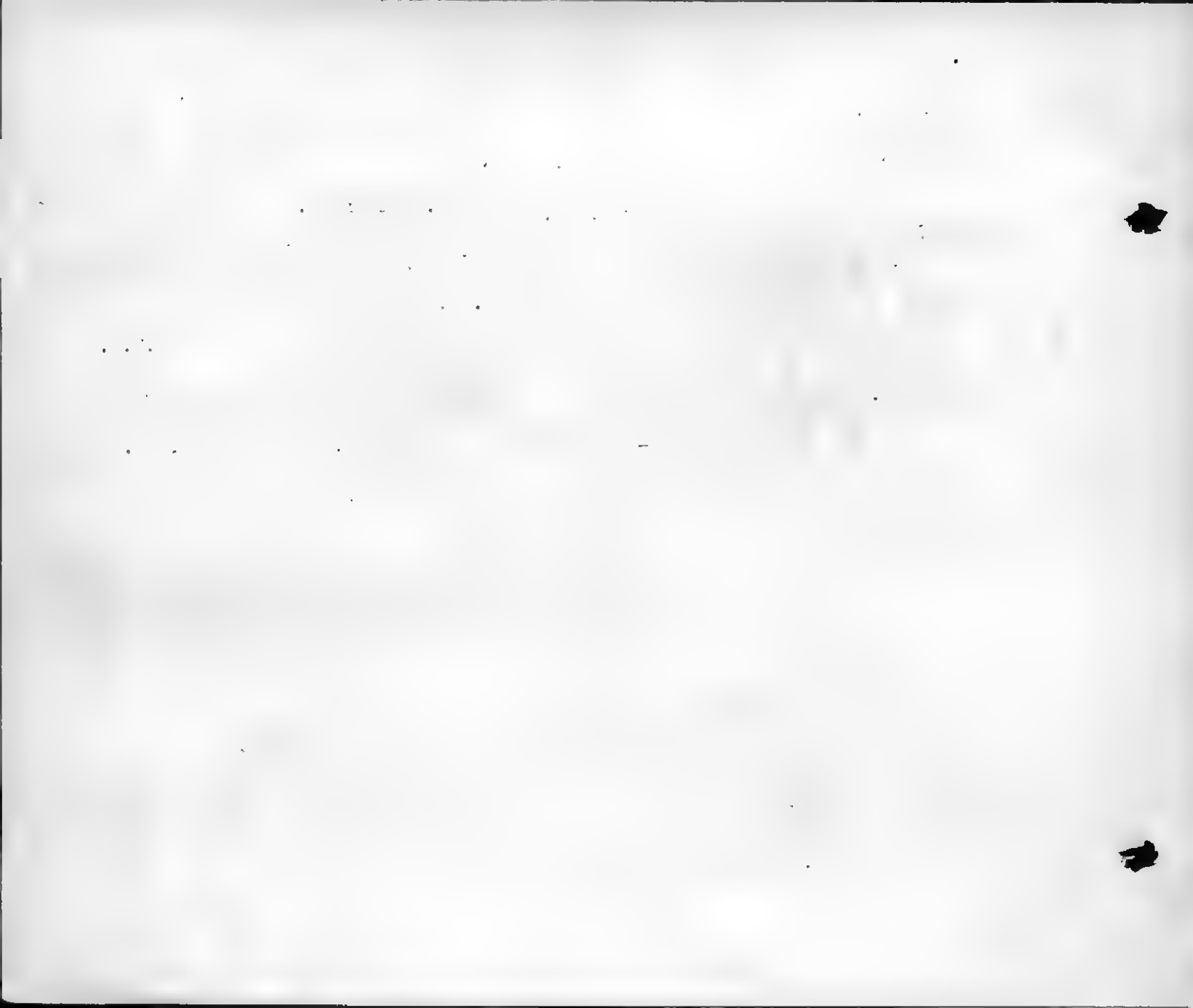


I. Gertrude Waggoner 167 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg		c. LENGTH OF STAY IN 1b 6 yrs 9 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Asbury Methodist Home for the Aged, Inc.				d. STREET ADDRESS 2205 E. Oliver St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE First WAGGNER Middle Last				4. DATE OF DEATH JULY 21 1960 Month Day Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1883		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Waggoner				14. MOTHER'S MAIDEN NAME XXXXXXXX Sarah Jane (nee Kirby)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 213-01-1253		INFORMANT Address Asbury Home records, Gaithersburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ARTEROSCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE OF LEFT HIP INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-20 , 19 56 , to 7-21 , 19 60 , that I last saw the deceased alive on 7-21 , 19 60 , and that death occurred at 6 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 10128 CEDAR LANE KENSINGTON, MD DATE SIGNED 7-21-60							
ACTUAL SIGNATURE Sarah E. Glover				M.D. 10128 CEDAR LANE KENSINGTON, MD			
PHYSICIAN'S NAME (Type) Sarah E. Glover							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/60		22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Son ADDRESS Baltimore - 17, Md.				24a. REC'D BY REGISTRAR DATE JUL 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1549 9/59

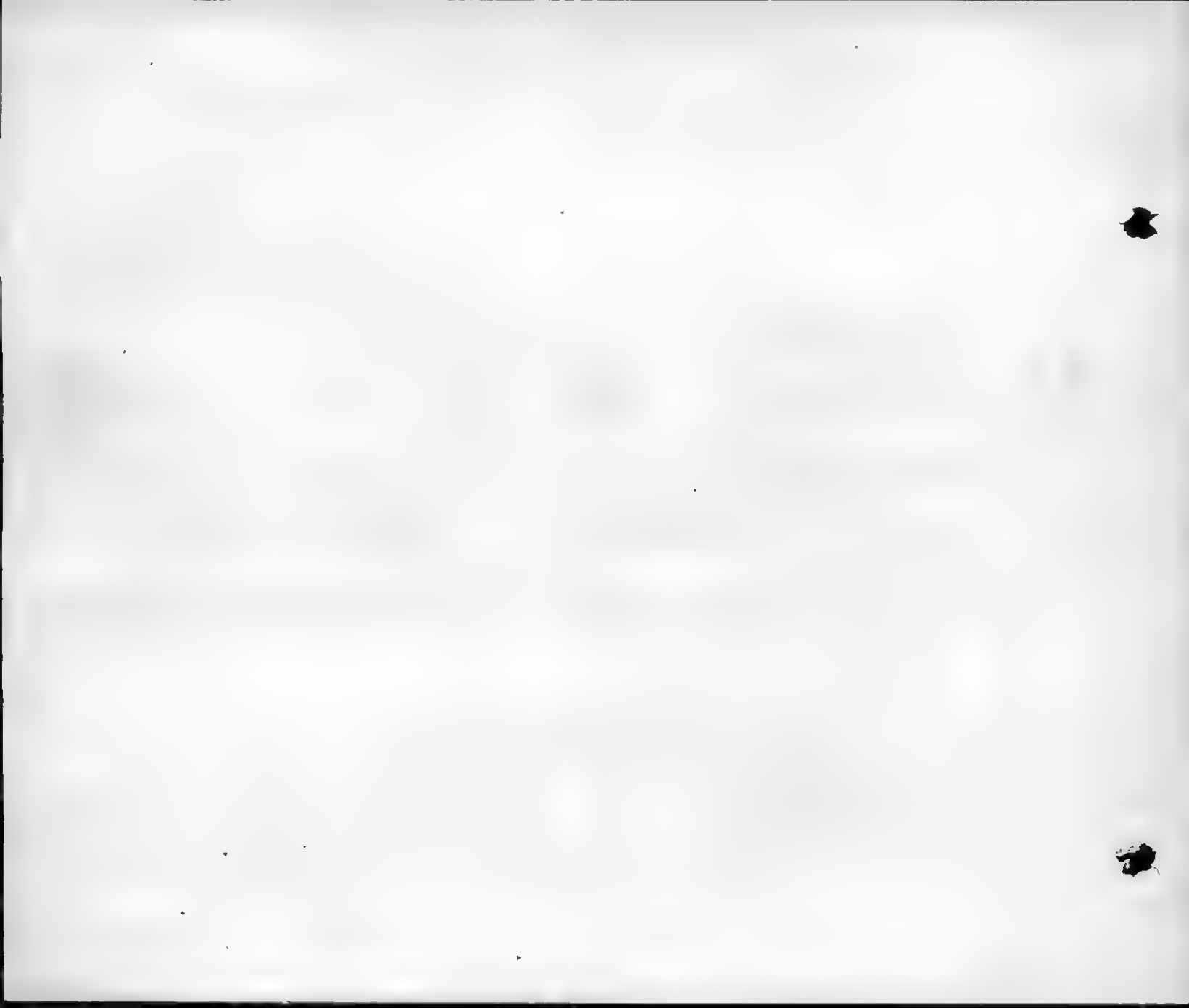
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8285
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08260

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 2 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Montgomery General Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH Month July Day 25 Year 1960		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 25, 1960		9. AGE (In years last birthday) 1 10. IF UNDER 1 YEAR Months 1 Days 55	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carlton Wendell Ward		14. MOTHER'S MAIDEN NAME Sandra Norson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT mother		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity, Immaturity 77 lb. (Weight 1 lb. 1005.) Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> -lying cause lost DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-25-1960 to 7-25-1960 that (I) (we) last saw the deceased alive on 7-25-1960 and that death occurred at 8:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jack Schumacher		22d. ADDRESS Gaithersburg, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-26-60	
23c. NAME OF CEMETERY OR CREMATORY Wesley Grove		23d. LOCATION (City, town, or county) (State) Woodfield, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber		25a. REC'D BY REGISTRAR DATE JUL 29 '60	
ADDRESS Paytonsville, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2073222XV



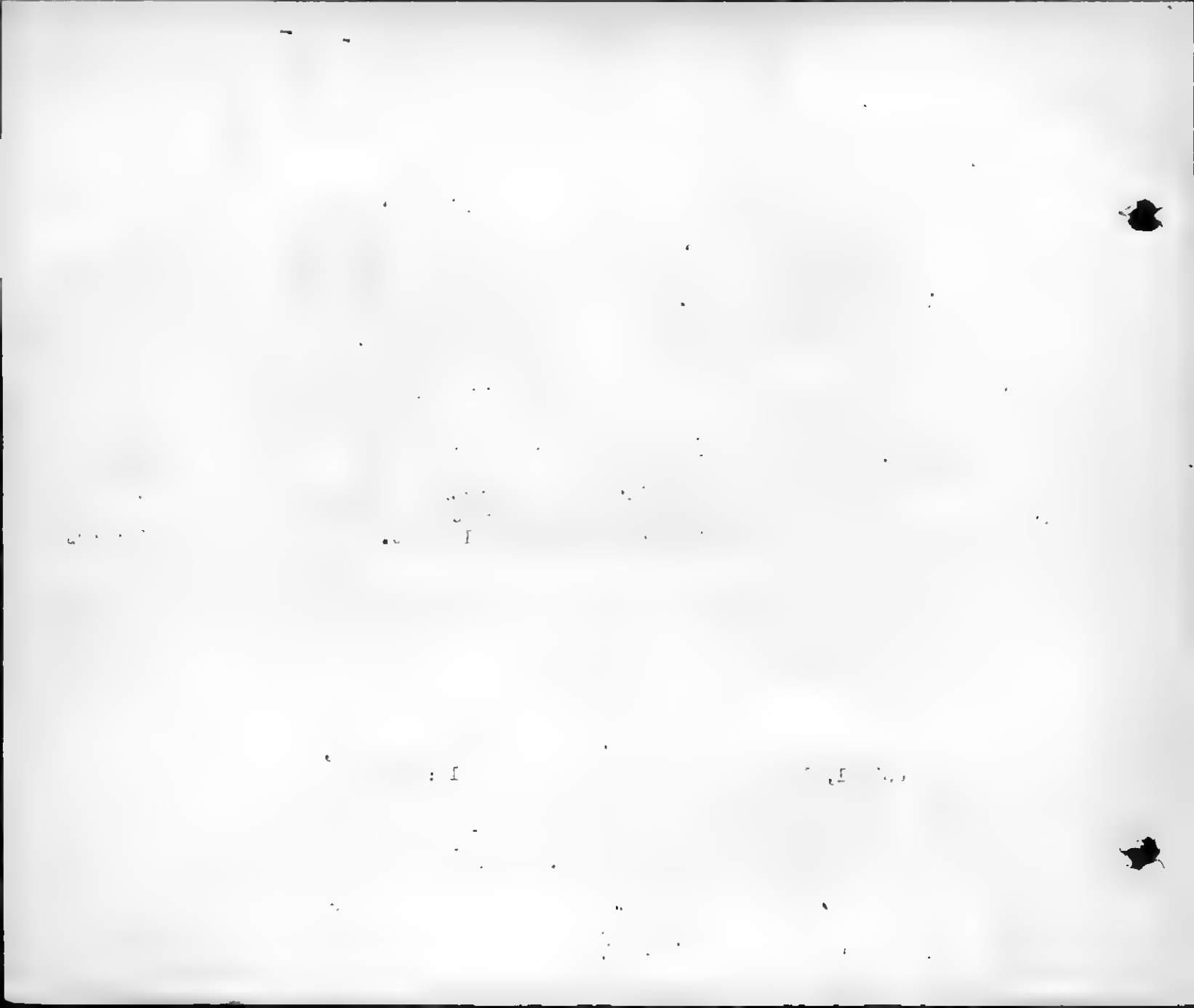
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8186

CERTIFICATE OF DEATH

Reg. Dist. No. 08261

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Viers Mill Road</u>		d. STREET ADDRESS <u>812 Viers Mill Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA</u> <u>BELLE</u> <u>WARREN</u>		4. DATE OF DEATH Month Day Year <u>Jul</u> <u>2</u> , <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 25, 1885</u>
9. AGE (In years last birthday) yrs. <u>74</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edwin B. Warren</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Pledger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Bobbie W. Wells-Item # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Common bile duct obstruction</u> DUE TO <u>Carcinoma of the pancreas with metastases to the region of the common bile duct.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 28, 1960</u> , to <u>July 2, 1960</u> , that I last saw the deceased alive on <u>July 1, 1960</u> , at <u>10:00 AM</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold S. Tidler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Harold S. Tidler-402 Fenton Street, Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler-1331 E. M. Ave. Rockville, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 6 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

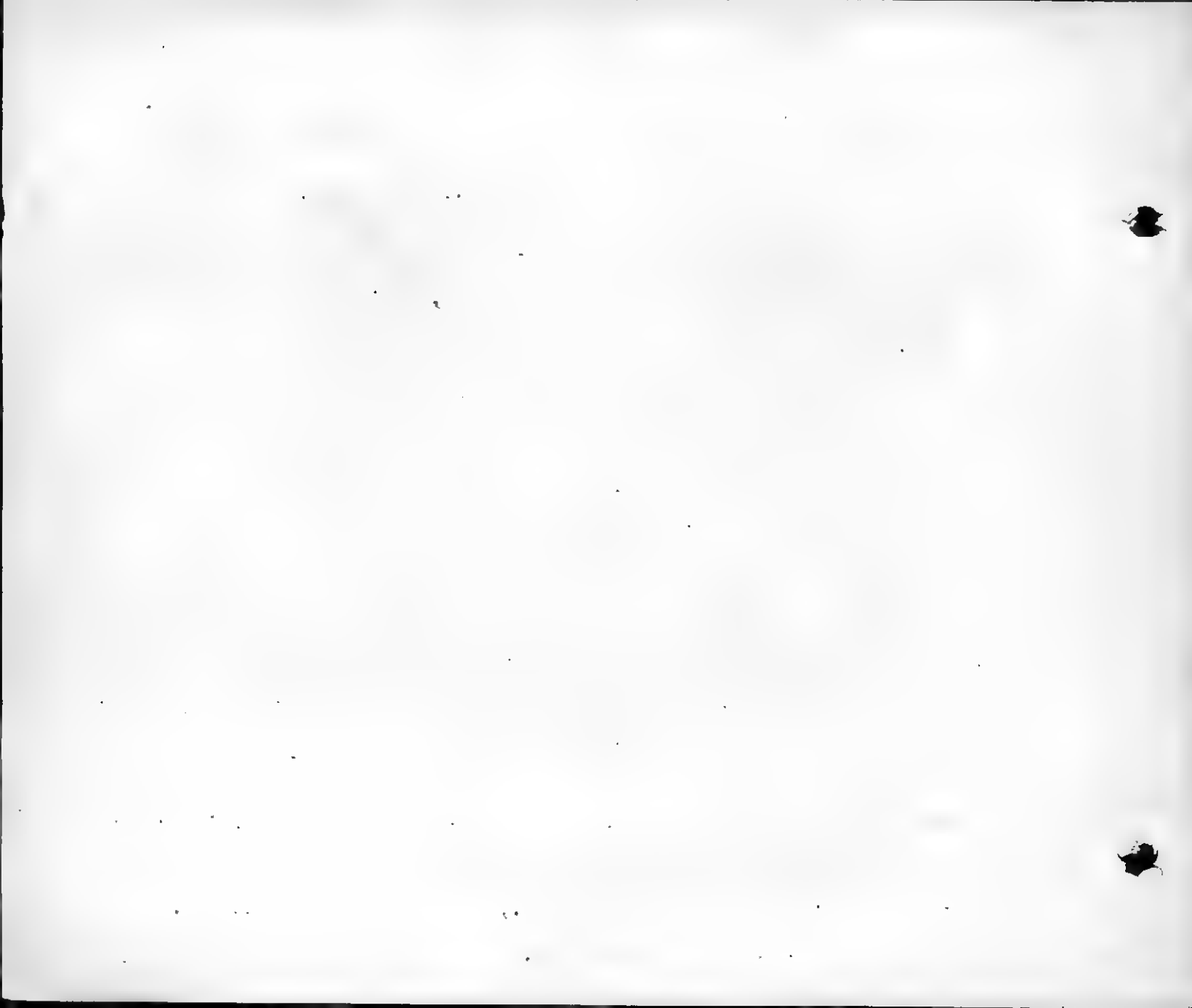


8286

CERTIFICATE OF DEATH

08262
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montg.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lincoln Park		c. LENGTH OF STAY IN life life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Washington Last Washington		4. DATE OF DEATH Month July Day 5 Year 1960	
5. SEX fem	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12, 1886
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR: Months 7 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME William Holly		14. MOTHER'S MAIDEN NAME Caroline ? UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Abdominal & Thoracic DUE TO Carcinoma Pelvic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Pelvic (c) Carcinoma Pelvic			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) 1977			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month July Day 4 Year 1960 Hour 11:35 a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Norbeck, Silver Spring, Md. (County) Rockville, Md. (State) Md.	
21. I certify that I attended the deceased from June 27, 1960 to July 5, 1960 that I last saw the deceased alive on July 4, 1960 , and that death occurred at 11:35 A.M. the causes and on the date stated above.			
ACTUAL SIGNATURE Webster Sewell M.D.		ADDRESS (Street, city or town, state) Norbeck, Silver Spring, Md. DATE SIGNED 7/8/60	
PHYSICIAN'S NAME (Type) Webster Sewell			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/8/60	
22c. NAME OF CEMETERY OR CREMATORY Lincoln Park.,		22d. LOCATION (City, town, or county) Rockville, Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Swodes ADDRESS Rockville, Md.		24a. REC'D BY REGISTRAR DATE JUL 13 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

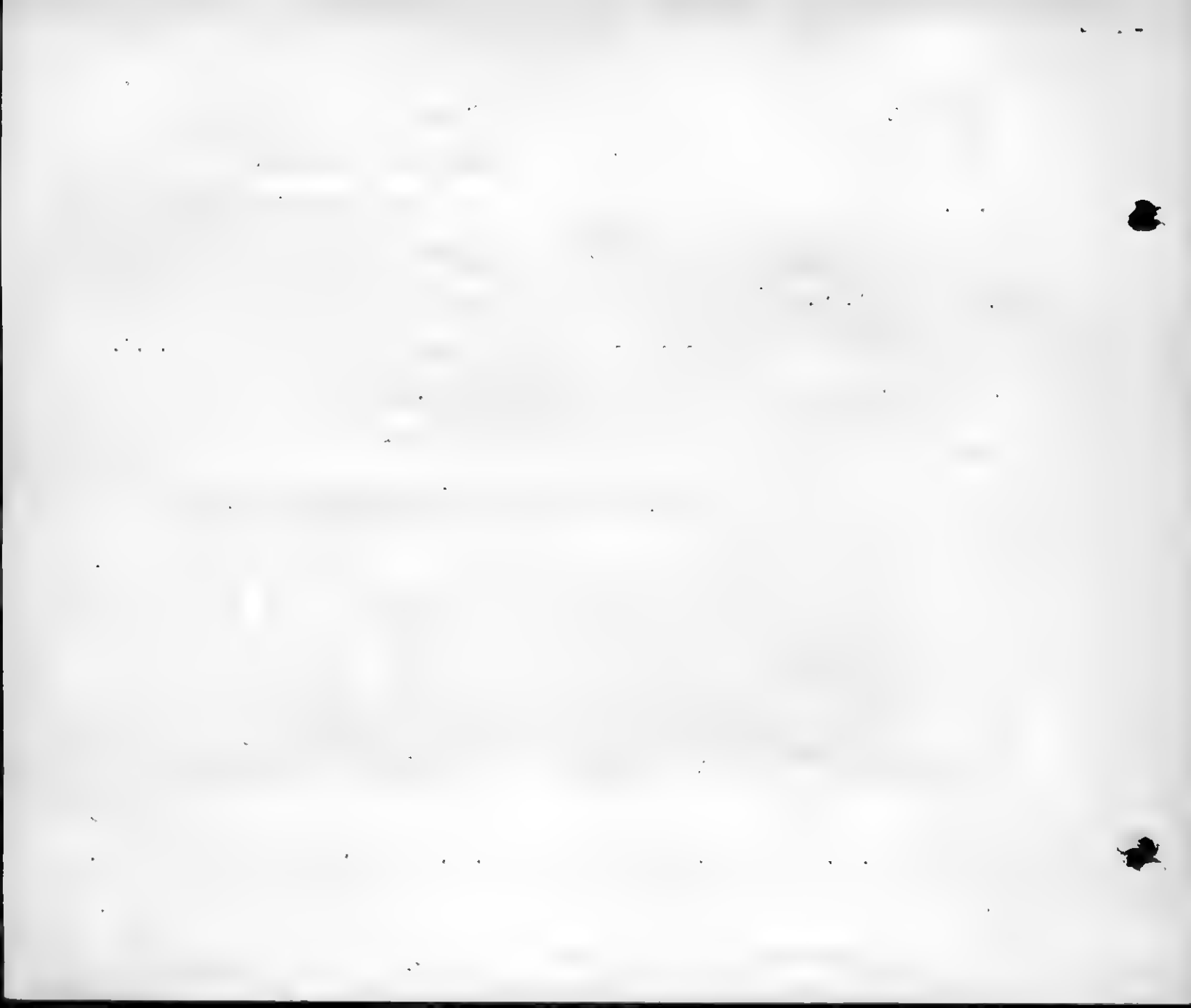


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 268 8-2-6 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
8287 CERTIFICATE OF DEATH

08263

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE Maryland b. COUNTY Calvert ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)				c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salmon SOLOMONS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital				d. STREET ADDRESS 216, Naval Air Station Annex		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Robert Last WATERS				4. DATE OF DEATH Month July Day 24 Year 19 60			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-5-57	
9. AGE (In years lost birthday) 2 yrs.		10. UNDER 1 YEAR Months 2 Days 24 Hours 19 Min. 60		11. BIRTHPLACE (State or foreign country) Florida		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Howard WATERS				14. MOTHER'S MAIDEN NAME Evelyn H. HOPE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) increased intracranial pressure 340.3 DUE TO and myocarditis with cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Meningo-encephalitis, organism unknown DUE TO meningo-encephalitis + myocarditis (c) meningo-encephalitis + myocarditis						INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the deceased) attended the deceased from July 24 1960 to July 24 1960 , that (I) (the deceased) saw the deceased alive on July 24 1960 , and that death occurred at 3:10 PM M, from the causes and on the date stated above							
22a. SIGNATURE G. B. AVERY, LT, MC, USN				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-25-60	
22c. PHYSICIAN'S NAME (Type) G. B. AVERY, LT, MC, USN				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Shipment		23b. DATE THEREOF 7-27-60		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park		23d. LOCATION (City, town, or county) (State) Greenville South Carolina	
24. FUNERAL DIRECTOR'S SIGNATURE Harkness Funeral Home, Mutual, Maryland				25a. REC'D BY REGISTRAR DATE JUL 28 '60		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

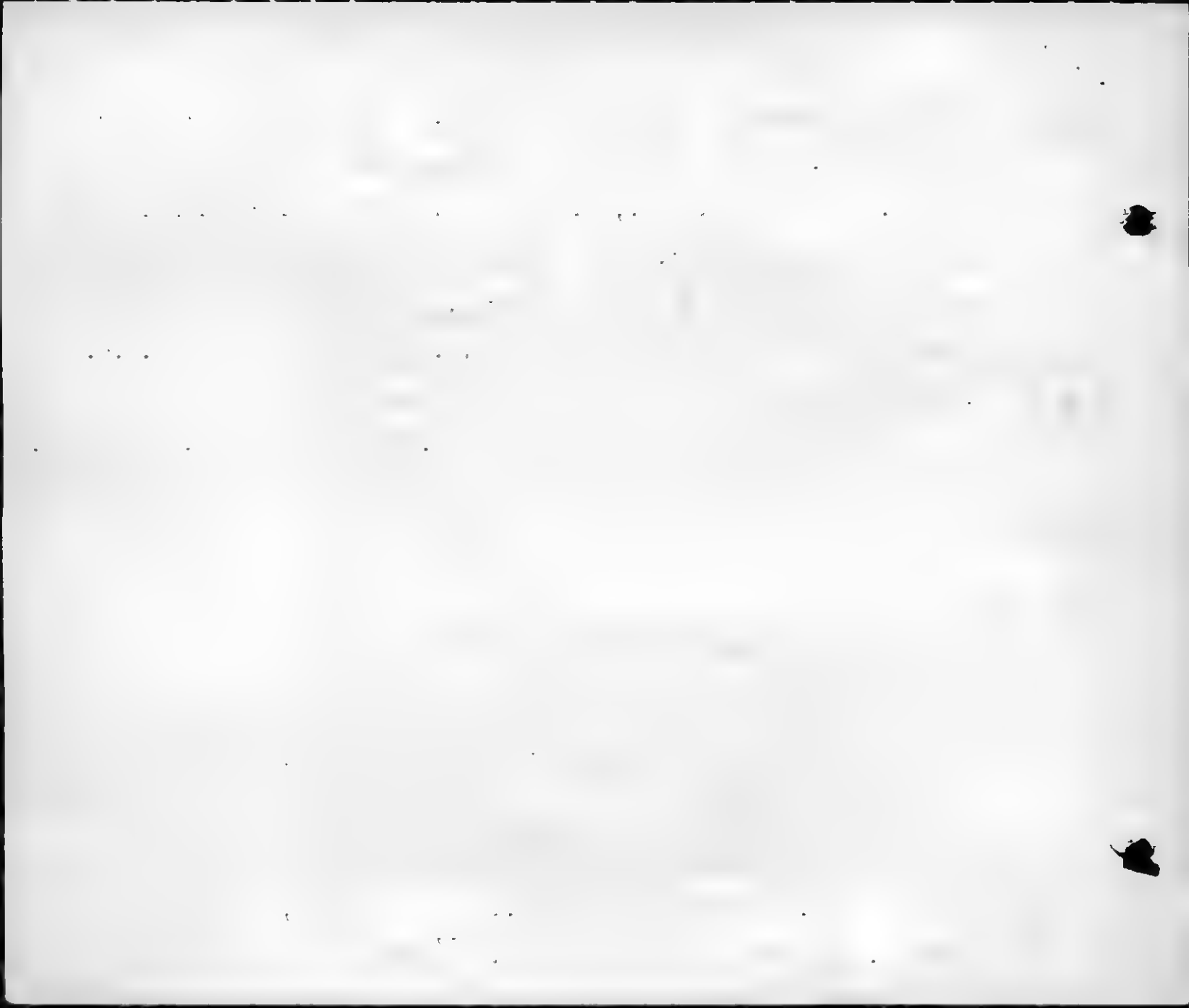
8288 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

08264

1 PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Bethesda, Md.				c. LENGTH OF STAY IN 1b 2½ years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4609 S. Chelsea La., Beth., Md.				d. STREET ADDRESS 4609 S. Chelsea La., Beth., Md.			
3. NAME OF DECEASED (Type or print) Minnie A. Webster				4. DATE OF DEATH Month July Day 30 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1870		9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Josiah Clark			
14. MOTHER'S MAIDEN NAME Mary Bartlett				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. None				17. INFORMANT Stewart H. Webster, 4609 S. Chelsea La.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral arteriosclerosis DUE TO (c) generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/16 19 60 to 7/30 19 60 , that (I) (we) last saw the deceased alive on 7/28 19 60 , and that death occurred at 5:45 P. from the causes and on the date stated above.							
22a. SIGNATURE Thomas F. O'Connor				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/30/60	
22c. PHYSICIAN'S NAME (Type) THOMAS F O'CONNOR, M.D.				22d. ADDRESS 4861 BATTERY LANE BETHESDA 14, MD			
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 5, 1960		23c. NAME OF CEMETERY OR CREMATORY Hillside Cem.,		23d. LOCATION (City, town, or county) (State) Holley, New York	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				25a. REC'D BY REGISTRAR 7559 Wisconsin Ave. Bethesda 14, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

(M)
X

(I)



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8130

CERTIFICATE OF DEATH

Reg. Dist. No.

08265

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>2 YRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN LUTHER NURSING HOME</u>		d. STREET ADDRESS <u>14511 COLESVILLE RD.</u>	
3. NAME OF DECEASED (Type or print) <u>ALICE BERRY WHALING</u>		4. DATE OF DEATH <u>JULY 15TH 1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8TH 1976</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours M'n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>WASHINGTON DC.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE BERRY</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>NONE</u>	
17. INFORMANT <u>VIRGINIA BITONES</u>		Address <u>6004 NEVADA AVENUE WASH. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Cardiovascular System</u> 4001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 - Acute myocardial infarction</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 19, 1958</u> to <u>July 15, 1960</u> that I last saw the deceased alive on <u>July 14, 1960</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John S. Rogers</u> M.D.		ADDRESS (Street, city or town, state) <u>1919 SEMINARY RD. SILVER SPRING MD</u>	
PHYSICIAN'S NAME (Type) <u>JOHN S. ROGERS</u>		DATE SIGNED <u>JULY 15, 1960</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/19/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suithard Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chaworth</u> ADDRESS <u>517 11th St. S.E.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 19 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. James</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

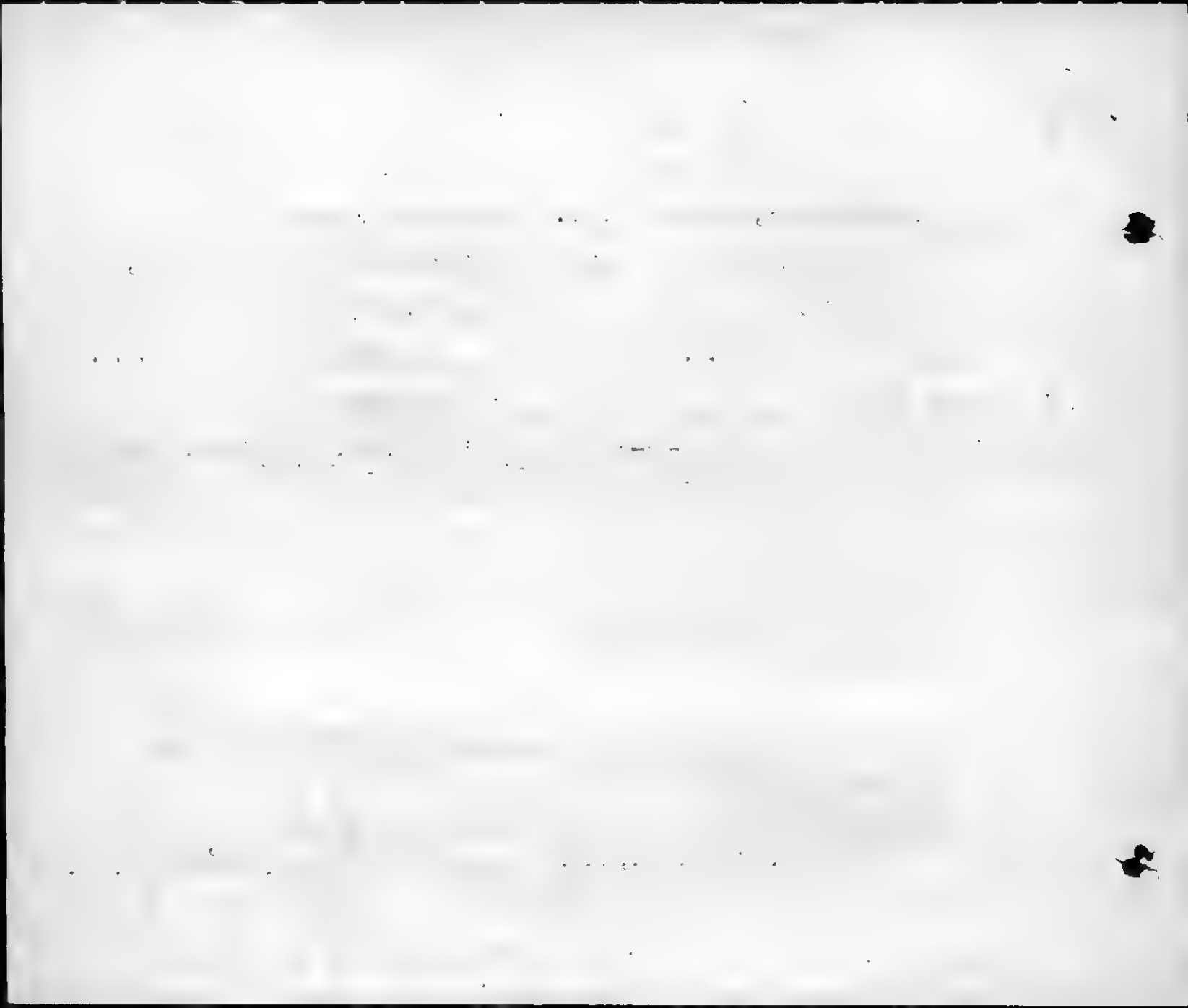


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

0826

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Fairfax			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 246 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Falls Church			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 104 South Virginia Avenue			
3. NAME OF DECEASED (Type or print) First John Middle Louis Last Whittaker				4. DATE OF DEATH Month July Day 7 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 11, 1933		9. AGE (In years last birthday) 26 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY U.S. Government		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Moniz				14. MOTHER'S MAIDEN NAME Irene Whittaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No		16. SOCIAL SECURITY NO 016-24-8655		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 1977-9 Synovial Sarcoma - Right Hip with metastasis to lungs & bone DUE TO (b): Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, DUE TO (c):				INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from November 4, 1959 to July 7, 1960 that (I) (we) last saw the deceased alive on July 7, 1960 , and that death occurred at 5:24 PM on the causes and on the date stated above.							
22a. SIGNATURE George F. Miller, Jr.				M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 7/8/60	
22c. PHYSICIAN'S NAME (Type) George F. Miller, Jr., M.D.				22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7/11/60		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City, town, or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey				ADDRESS Bethesda, Maryland		25a. REC'D BY REGISTRAR JUL 12 '60	
				25b. REGISTRAR'S SIGNATURE Orlando S. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

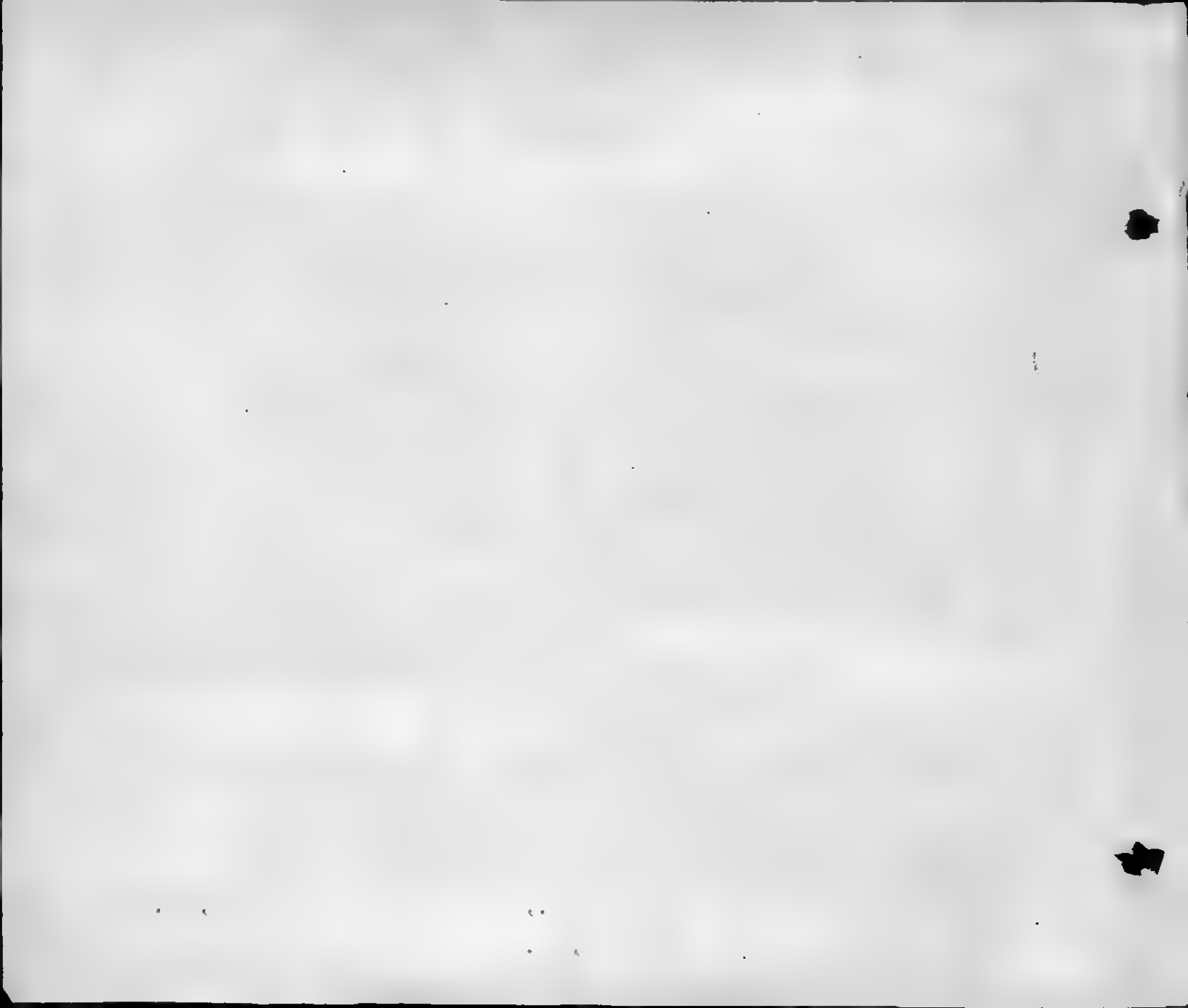
VS. A15ME
PM 7/59

None

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8168 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08262

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Faithersburg (rural)</u>	
c. LENGTH OF STAY IN life <u>life</u>		d. STREET ADDRESS <u>Elkision unity Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Elkision - unity Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brauda Lee Williams</u>		4. DATE OF DEATH <u>July 3 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-18-1946</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE (In years, last birthday) <u>15</u> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herman Williams Dorsey</u>		14. MOTHER'S MAIDEN NAME <u>Selma Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Selma Williams - 12</u>	
17. INFORMANT <u>Selma Williams - 12</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>475X Asphyxia</u> DUE TO (b) <u>Upper Resp. Infection</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>Found dead in bed</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D.	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DATE SIGNED <u>7-3-60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/5/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooke Grove.,</u>		22d. LOCATION (City, town, or country) (State) <u>Laytonsville, Md.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Suroden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DAHL 6 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 8268

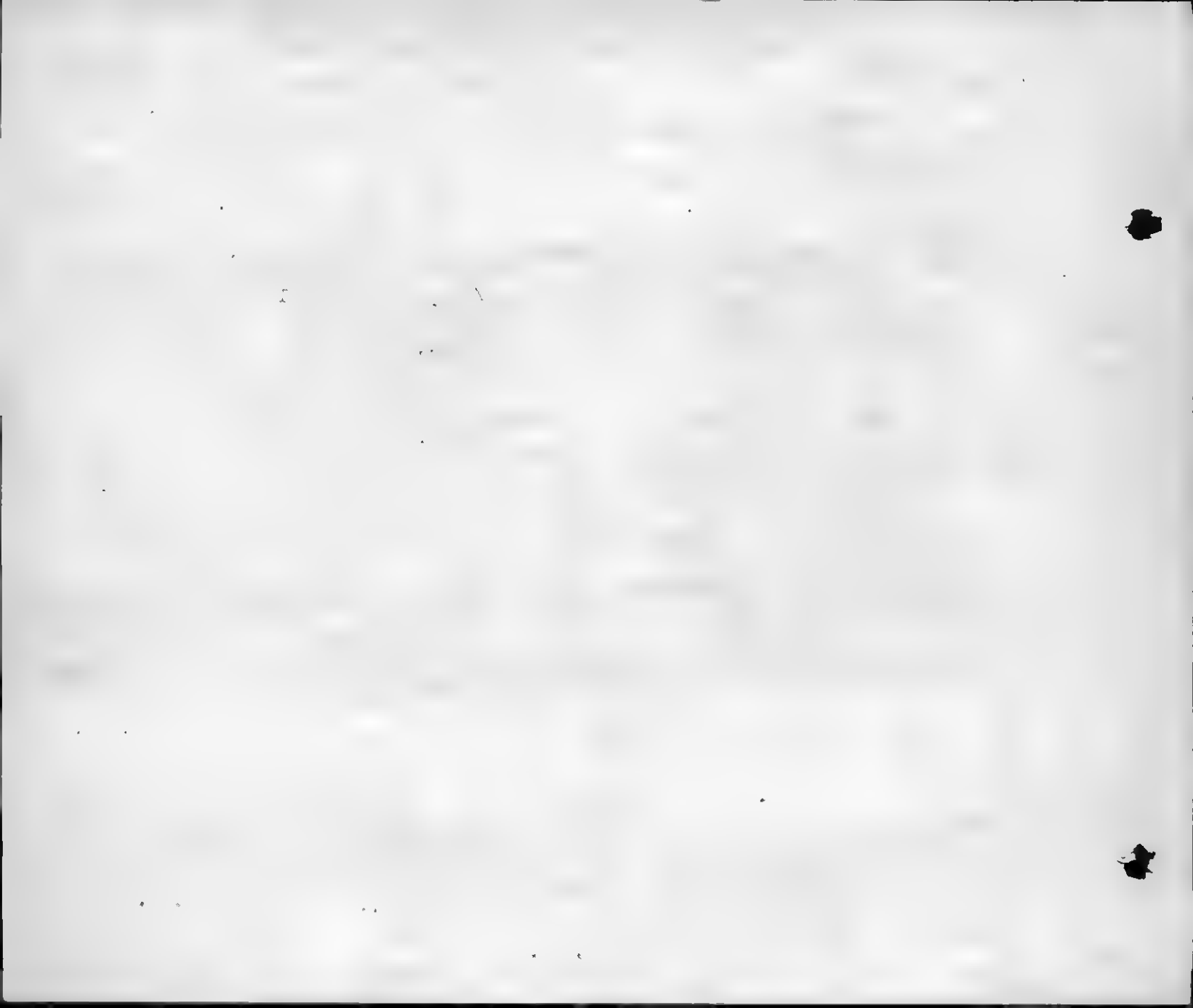
8131

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring (rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colesville - Fairland Rd.</u>				d. STREET ADDRESS <u>Colesville- Fairland Rd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ZILPHIA</u> Middle <u>WINKIE</u> Last				4. DATE DEATH Month <u>July</u> Day <u>3</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/1909</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ORANGE, VIRGINIA</u>	
13. FATHER'S NAME <u>Robert Winkie</u>				14. MOTHER'S MAIDEN NAME <u>Mary Synder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Police Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Herniation of brain stem</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cerebral edema</u> (c) <u>Subdural Hemorrhage</u> causing the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>hrs.</u> <u>hrs.</u> <u>hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Reported beaten by common law husband</u>					
20c. TIME OF INJURY Month, Day, Year <u>7/3/60</u> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Silver Spring Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>7/4/60</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7/6/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Taft Williams Funeral Home.,</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Swenden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 11 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Curtis L. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

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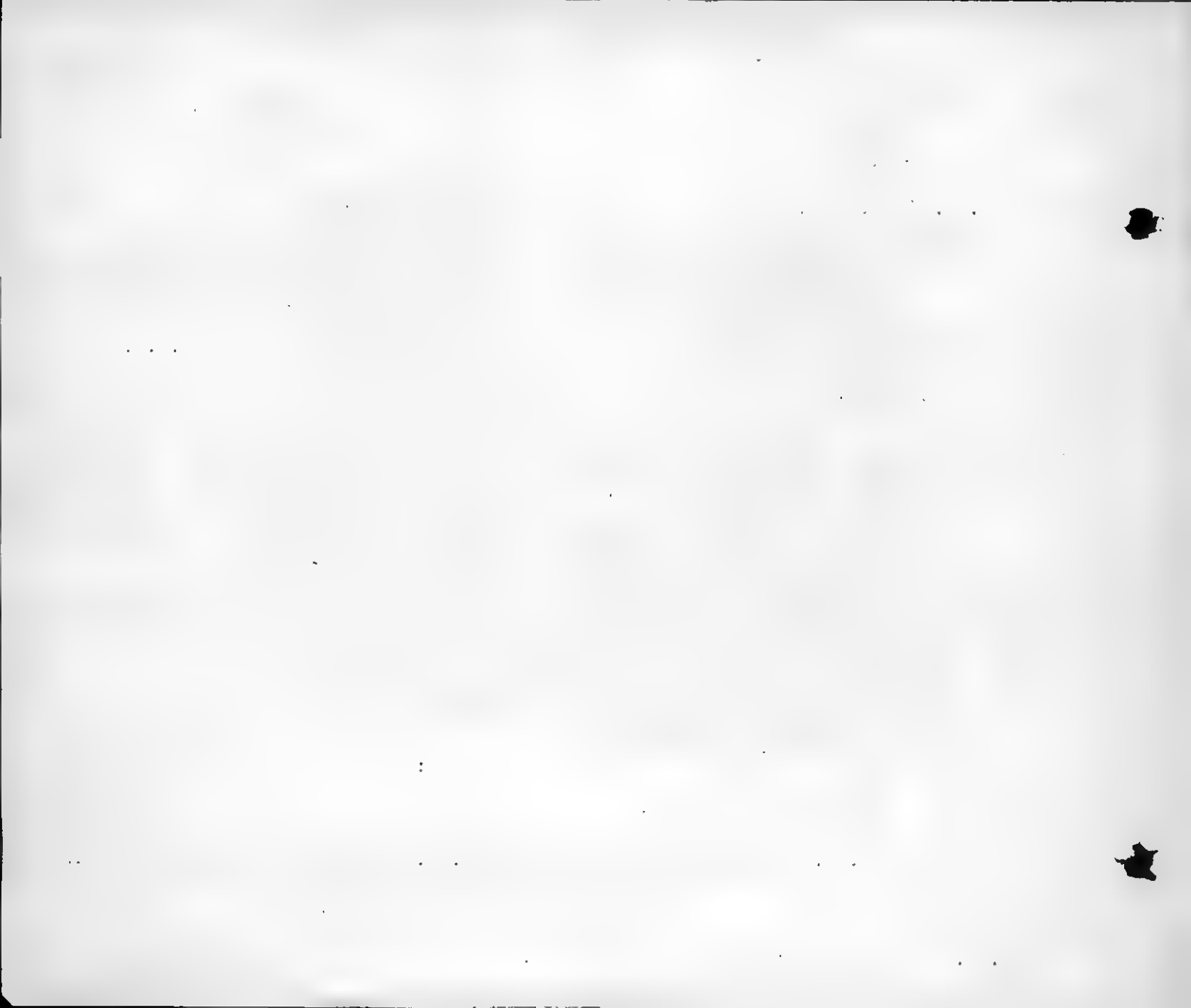
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0826J

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural) c. LENGTH OF STAY IN 1b 7 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Naval Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 11229 Ashley Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Alan Middle Edward Last WITHAM		4. DATE OF DEATH Month July Day 20 Year 1960							
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-8-57	9. AGE (In years last birthday) 3 yrs	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS Days 3	12. IF UNDER 24 HRS Hours 3	13. IF UNDER 24 HRS Min. 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Washington		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John M. WITHAM		14. MOTHER'S MAIDEN NAME Helen M. PASCOE							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congenital heart disease - ventricular septal defect with moderate pulmonary hypertension (post operative status) DUE TO hypertension (post operative status) DUE TO hypertension (post operative status) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None								INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Rockville		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 13 9:50PM to July 20 , 19 60 , that (I) (we) last saw the deceased alive on July 20 , 19 60 , and that death occurred at 9:50PM , from the causes and on the date stated above.									
22a. SIGNATURE J. E. MC CLENATHAN		M D		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-21-60			
22c. PHYSICIAN'S NAME (Type) J. E. MC CLENATHAN, CDR, MC, USN		U. S. Naval Hospital, Bethesda, Md.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 7-22-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington Virginia			
24. FUNERAL DIRECTOR'S SIGNATURE R. A. Humphrey		ADDRESS Bethesda, Md.		25a. REC'D BY REGISTRAR JUL 25 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Frank			



1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

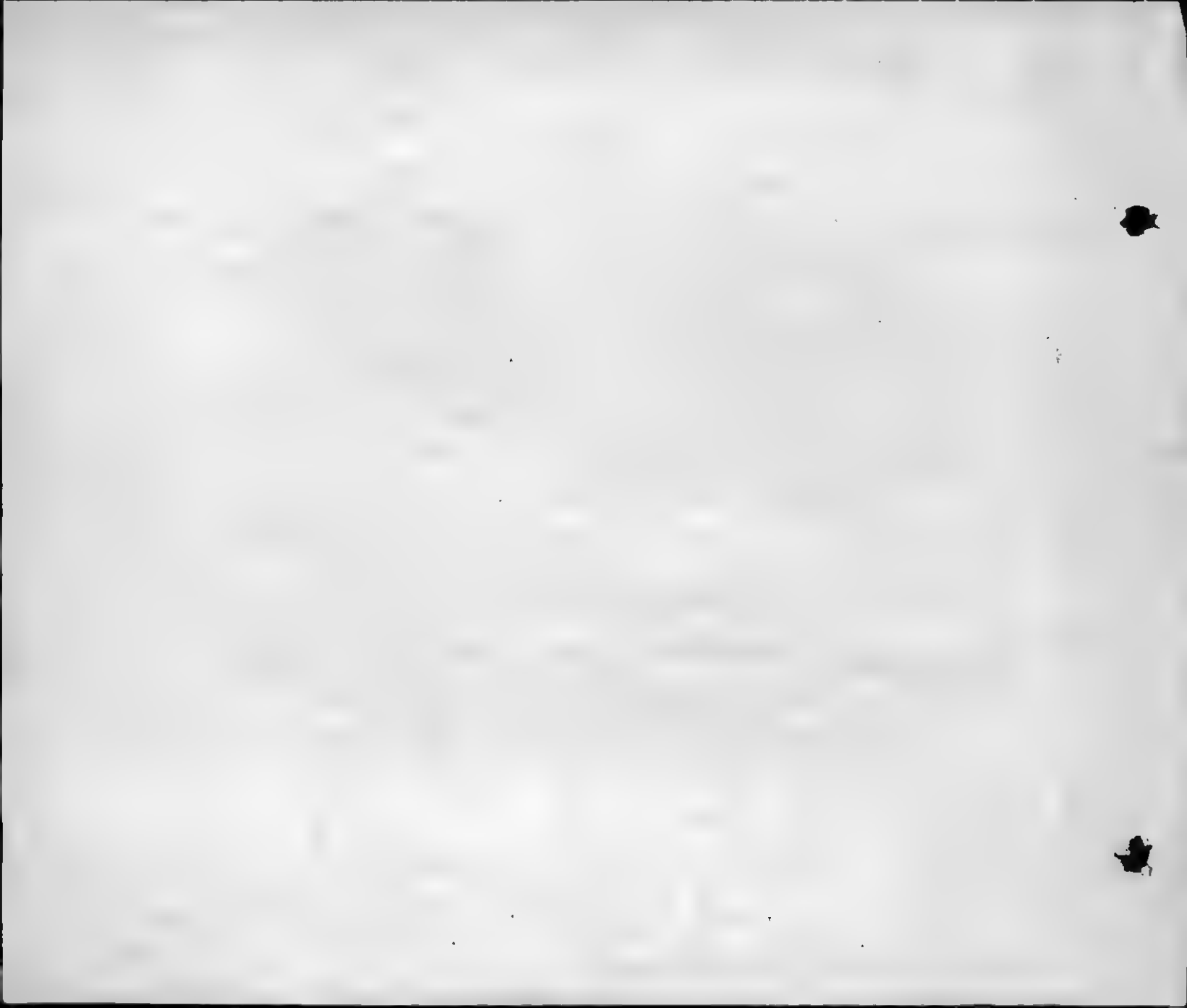
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
8132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08270

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. place before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (If outside corporate limits, to RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>14 yrs</u>		d. STREET ADDRESS <u>10238 Capitol View Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (not in hospital, give street address) <u>10238 Capitol View Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Earl Witherite</u>		4. DATE OF DEATH <u>July 12 1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-21-1899</u>
9. AGE (In years, last birthday) <u>60 yrs</u>	10. IF UNDER 1 YEAR Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PEX telephone repairman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>C&P Telephone Co. Va</u>	
13. FATHER'S NAME <u>Adam Witherite</u>		14. MOTHER'S MAIDEN NAME <u>Minnie McCarthy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WW #1</u>		16. SOCIAL SECURITY NO. <u>577-01-3327</u>	
17. INFORMANT <u>Pearl Witherite (wife)</u>		Address <u>Illen 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> stating the underlying cause last. (c) <u></u> DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> e.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brocchant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brocchant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>July 14, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATL. CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR <u>WARNER E. PUMPHREY, INC., SILVER SPRING, MD</u>		24a. REC'D BY REGISTRAR <u>JUL 18 '60</u>	
Address <u>Raymond A. Ziska</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
Grand death in bed



8291

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>3 yr 7 mo</u>		d. STREET ADDRESS <u>13 Pooks Hill Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Pooks Hill Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edythe</u> Middle <u>G</u> Last <u>Zartman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3, 1901</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pa.</u>	11. BIRTHPLACE (State or foreign country) <u>USA</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Rolandus Wenger</u>	
14. MOTHER'S MAIDEN NAME <u>Ella E. Weaver</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>577-50-7414</u>		17. INFORMANT <u>S.F. Zartman</u> Address <u>3 Pooks Hill Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>157X Carcinomatosis</u> DUE TO (b) <u>Carcinoma of pancreas</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12/30</u> 19 <u>59</u> , to <u>present</u> 19 <u>60</u> , that I last saw the deceased alive on <u>7/24</u> 19 <u>60</u> , and that death occurred at <u>11:48 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhau</u> M.D.		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave</u> DATE SIGNED <u>7/25/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN B. UMHAU</u>		<u>Cherry Chase 15 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-transit</u>	22b. DATE THEREOF <u>7/28/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St John's Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brickerville, PA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 26 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1911

[Faint, mostly illegible text from a death certificate form, including fields for name, age, sex, date of death, and cause of death.]



21

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8292

CERTIFICATE OF DEATH

Reg. Dist. No. 08272

1. PLACE OF DEATH a. COUNTY Marileia Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colesville Md.		c. LENGTH OF STAY IN 1b 8 years ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Marilea Rest Home		d. STREET ADDRESS 7217 Forest Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Zervakos		4. DATE OF DEATH Month July Day 21 Year 1960	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1886
9. AGE (In years last birthday) 74 yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Athens Greece		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Nikita Stratigopoulos		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Straty Zervakos		Address Kent Village Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chronic cardiovascular disease (c) 15 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH 40 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 8, 1957 to July 21, 1960 , that I last saw the deceased alive on July 21, 1960 , and that death occurred at 12:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE John C Rogers M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 1919 Silver Springs Road, Silver Springs, Maryland. 7-31-60	
PHYSICIAN'S NAME (Type) John C Rogers			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/23/60	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn New York	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		ADDRESS Hyattsville, Md.	
24a. REC'D BY REGISTRAR JUL 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

MARITAL STATUS

PROFESSION

CAUSE OF DEATH

DATE OF BURIAL

1. Name of deceased
2. Date of birth
3. Place of birth
4. Age at death
5. Sex
6. Race
7. Education
8. Religion
9. Marital status
10. Profession
11. Cause of death
12. Date of burial

13. Name of physician
14. Name of funeral home
15. Name of cemetery
16. Name of undertaker
17. Name of registrar
18. Name of health officer
19. Name of coroner
20. Name of judge